Reg. Dist. No.

		The same									
					2. USUAL P	RESIDENCE (WI	nere decease	d lived. If instituti	on: Residence	before admir	ssion)
. (Carroll			MARYLAND	1			Balt	imore		
			ts, write	c. LENGTH OF STAY IN 16	c. CITY	OR TOWN (IF	outside carpo	rate limits, write A	URAL and giv	ve nearest taw	rn)
	vkesvill	e		19 days	Bal	timore		3 V	01-4	4	
d.	NAME OF HOSPIT	AL (If not in hospital, g	ive street (oddress)						e. IS RE	SIDENCE A FARM?
- 6	pringfie	eld State H	ospit	al	165	5 E. C	old Sp	ring Lan	e] NO [3
DE	CEASED	Wayne		Middle	Batto	last	4. DATE OF DEATH			Doy 16	Yeor 19 58
5. SEX		6. COLOR OR RACE	7. MARR	IED NEVER MARRIED	B. DATE OF E	BIRTH	0115	9. AGE (In years			
7	fole.	White	WIDOWE	D DIVORCED	June	30. 19	20	38 yrs.	Months D	ays Hours	Min.
10a. L	SUAL OCCUPATION	N (Give kind of work	done 10b.	KIND OF BUSINESS OR IND				ountry)	12. CITIZ	EN OF WHA	T COUNTRY?
			,		7.7.	at Vin	ad mil a		17	C A	
		akter.					Character and		0.1	D.A.	
1	tleming	-			1	Blanci	ha				
					1	largare	t/Zerv				
IS: W.	o. or unknown)	R IN U. S. ARMED FOR (If yes, give war or dates of s	CES7 16. ervice)	SOCIAL SECURITY NO. 17.	INFORMANT			Add	ress		
ن	20	-	23	3-12-7177	Spring	Tield H	ospita	1 Record	S		
18	. CAUSE OF DEA	TH [Enter only one co	use per lin	e far (o), (b), and (c).						INTERVAL B	ETWEEN
8	- PART I. DEA	TH WAS CAUSED BY:	To	ennects cirrl	neie						
	5911			CIMIOC & CITIT	00104					MOHEN	
)								
-	ying couse lost.) (c)								
ğ	PART II. OTH	IER SIGNIFICANT CON	DITIONS C	CONTRIBUTING TO DEATH BL	T NOT RELATED	TO THE TERM	INAL DISEAS	E CONDITION GIV	VEN IN PART 1	(0) 19. WAS	ORMED?
3	ABS asso	ciated wit	h alc	cholism plus	CRS ass	ociate	i with	alcohol	iem		NO
L 2	a. ACCIDENT WA	S LINDFRIYING []	20b. DESC	RIBE HOW INJURY OCCUR	ED. (Enter notu	re of injury in	Port I or Por	t II of item 18.)	100		
# IN	EITHER, NOTIFY	MEDICAL EXAMINER)									
₹ 20	c. TIME OF INJUR	Y Manth, Day, Yes	or 20d. IN	JURY OCCURRED 20e. F	LACE OF INJU	RY (Home, form	20f. (City	ar town)	(Co	unty)	(Stote)
ă	Hour o. m.		While	_ Not while	octory, street, o	ffice bldg., etc	.)		,,,,,	//	(0.0.0)
						10		4 10			
2	1. I certify th	at I attended the	decease	ed fromSeptember	27, 195	28_, to_Q	ctobe	16, 1958	_,that I la	st saw the	decease
a	live on Oct	ber 16	. 19	58 , and that deat	h accurred	or 11:5	OM, fran	n the causes	and an the	date stat	ed abave
	0	**	0 /	1 0							ATE SIGNED
	CTUAL /	ushin ,	RIV	Cambo.	S	minafi	eld St	ate Hosp	ital	10/16	/58
	GNATURE		700	-cirrociec.	_M.D	AT TITET T	eta b	va de mosp	1 061.	107.10	1_2
21	1 /	and a									
PI	YSICIAN'S	m Pak mishaan	C	M-TD /	C.	T been and T	20 3/4	han free			
PIN	AME (Type)	Agustin del						aryland			
220. B	AME (Type)	N, 226. DATE THEREO		22c. NAME OF CEMETERY	OR CREMATOR		22d. LOCA	TION (City, town,	or county)	(Sto	ote)
22a. B	AME (Type)	N, 226. DATE THEREO			OR CREMATOR		22d. LOCA	TION (City, town,	inia		ote)
22a. B	URIAL, CREMATIO	10/19/		22c. NAME OF CEMETERY	OR CREMATOR	(em.	22d. LOCA	TION (City, town, st Virg	or county) inia STRAR'S SIGN		ole)
	d. J. S. SEX TOO. USE TO SEX T	RURAL and give ne Sykesvill d. NAME OF HOSPITION INSTITUTION Springfie 3. NAME OF DECEASED (Type or print) 5. SEX Male 100. USUAL OCCUPATION Steel Worth Market Steel Worth Market Steel Worth Stee	b. CITY OR TOWN (If autside corporate liming RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL (If not in hospital, goor Institution) Springfield State H 3. NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE White 10a. USUAL OCCUPATION (Give kind of work of during most of working life, even if refired Steel Worker 13. FATE'S NAME Fielding Batton 15. WAS DECEASED EVER IN U. S. ARMED FOR PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (of DUE TO Canditions, if ony, which gave rise to immediate cause (o), stoling the under: lying couse lost. PART II. OTHER SIGNIFICANT CON ABS ABSOCIATED TO THE SIGNIFICANT CON ABS ABSOCIATED WITH MEDICAL EXAMINER) 20a. ACCIDENT WAS UNDERLYING DO TO CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Yee Hour o. m. p. m. 19 21. I certify that I attended the alive on October 16	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL (If not in hospital, give street of OR INSTITUTION Springfield State Hospit 3. NAME OF DECEASED (Type or print) 5. SEX 6. COLOR OR RACE WIDOWE 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker 13. FATHER'S NAME FIELDING FIELDING FIELDING FIELDING FIELDING FIELDING FIELDING FATHER'S NAME (If yes, give wor or dates of service) 10a. WAS DECEASEDEVER IN U. S. ARMED FORCES? 11b. CAUSE OF DEATH [Enter only one couse per lime or unknown) 11c. WAS DECEASEDEVER IN U. S. ARMED FORCES? 11d. OTHER SIGNIFICANT CONDITIONS CONDITIONS CONTRIBUTING CONTRIBUTION CONTRI	O. COUNTY CARTOL b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) Sykesville d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital 3. NAME OF DECASED (Type or print) Wayne 6. COLOR OR RACE WIDOWED 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Steel Worker 13. FATHE'S NAME Fielding Batton 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give wor or dates of service) 16. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Canditions, if ony, which gave rise to immediate couse (o), stoling the under. VIENTAL OR OF CONTRIBUTING TO DEATH BL ABS ASSOCIATED TO CONTRIBUTION TO COURSED While at work at wo	D. CITY OR TOWN (if autside corporate limits, write RURAL and give nearest fown) Sylesytile d. NAME OF HOSPITAL (if not in hospital, give street address) Springfield State Hospital 3. NAME OF OPERASE (if not in hospital, give street address) Springfield State Hospital 3. NAME OF OPERASE (if not in hospital, give street address) Springfield State Hospital 3. NAME OF OPERASE (if not in hospital, give street address) Springfield State Hospital 3. NAME OF OPERASE (if not in hospital, give street address) Springfield State Hospital 3. NAME OF OPERASE (if not in hospital, give street address) Springfield State Hospital 3. NAME OF OPERASE (if not in hospital, give street address) Springfield State Hospital 4. STATE (if not in hospital, give street address) Springfield State Hospital 5. SEX (a. Color or RACE (if not in hospital, give street address) Male (if not in hospital, give street address) Male (if not in hospital, give street address) 6. Color or RACE (if not in hospital, give street address) Middle Determined (if not in hospital, give street address) 8. DATE OF ELLIPSE (if not in hospital, give street address) Middle Determined (if not in hospital, give street address) 8. DATE OF ELLIPSE (if not in hospital, give street address) Middle Determined (if not in hospital, give street address) 9. DATE OF ELLIPSE (if not in hospital, give street address) Middle Determined (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address) 10. NAME OF DATE (if not in hospital, give street address)	COUNTY CAPTOL CAPTOL	b. CITY OR TOWN (If outside corporate limits, write RURAL ond give nearest lown) Sykesyille d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital 3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital 3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital 3. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION OR INSTITUTION OR INSTITUTION Springfield State Hospital 4. DATE OF BIRTH OPEAN Male White WIDOWED DIVORCED DIVORCED June 30, 1920 10c. USUAL OCCUPATION (Cive kind of work done during most of working life, even if retired) Steel Worker Steel Worker Fielding Batton 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT 18. CAUSE OF DEATH [Enter only one course per line for (o), (b), and (c).] PART I. OFFINAME 19. PART II. OFFINAME SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEAS ABS ABSOCIATED WITH A CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEAS ABS ABSOCIATED 10. DESCRIBE HOW INJURY OCCURRED White OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO COURRED. (Enter nature of injury in Port for Port Conditions, If any, which gove rise to immediate (c) Conditions, if ony, which gove rise to immediate (b) DUE TO Conditions, if ony, which gove rise to immediate (c) Conditions on the significant Conditions Contributing To Death But not related to the Terminal Diseas ABS ABSOCIATED OUE TO Conditions, if ony, which gove rise to immediate (c) Contributing CAUSE OF DEATH (If Either, NOTHY MEDICAL EXAMINER) 20c. ACCIDENT WAS UNDERLYING 19. DESCRIBE HOW INJURY OCCURRED White Not white of work 19. Described Work 19. Described Work 19. One of the significant Conditions of work 19. One of the significant Conditions of the port of the significant Conditions, etc.) 20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED White OF THE STATE OF THE T	b. CITY OR TOWN (if outside corporate limits, write RURAL and give negres) town) Sykesyille d. NAME OF HOSPITAL (if not in hospital, give street oddress) Springfield State Hospital 3. NAME OF OCCUPATION (Give kind of work done) (If pro or print) Sykesy (I) 100. USUAL OCCUPATION (Give kind of work done) 100. USUAL OCCUPATION (Give kind of work done) 101. USUAL OCCUPATION (Give kind of work done) 102. USUAL OCCUPATION (Give kind of work done) 103. FAME'S NAME Fielding Batton 104. MOINES, MAIDEN NAME 105. West Virginia 105. West Virginia 106. COLOR OR RACE 107. MARRIED TINEVER MARRIED 108. KIND OF BUSINESS OR INDUSTRY 109. West Virginia 107. MOINES, MAIDEN NAME 108. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).] 108. CAUSE OF DEATH [Enter only one couse per line for (o), (b), ond (c).] 109. ACCIDENT WAS LUNDERVING (c) 100. DESCRIBE HOW INJURY OCCURRED (c) 100. DESCRIBE HOW INJURY OCCURRED (c) 100. ACCIDENT WAS LUNDERVING (c) 100. ACCIDENT WAS LUNDERVING (c) 100. DESCRIBE HOW INJURY OCCURRED (c) 100. ACCIDENT WAS LUNDERVING (c) 100.	D. COUNTY CATTOIL B. COUNTY CATTOIL C. CITY OR TOWN (if outside corporate limits, write c. LENGTH OF STAY IN 1b B. COUNTY SYLESY 11 1e C. ANAE OF COSTRAI (if not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital NAME OF COSTRAI (if not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital NAME OF COSTRAIN (if not in hospital, give street oddress) OR INSTITUTION Springfield State Hospital NAME OF OCCASED (Ifper or print) Wayne Elbert Batton 1655 E. Cold Spring Lane 1655 E. Cold	O. COUNTY CATTOIL b. CITY OR TOWN (If outside corporate limit, write

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 by the haspital or attending physician.

**TOR: After this certificate has been signed by the attending physician and campletely filled in by 14% funeral director, 1008: After this certificate has been signed by the attending physician and campletely filled in by 14% funeral director, 1008: may be retained TO FUNERAL DIV

1 WELDS AND 500 the control of the co Dr. -- considered Service Secretarion of Expenses a Net Average 1997 Din Lynn I STITUTED TO

MARYLAND STATE OF ARTMIND OF MEATHER - RESTINGUES 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11155

1	11168 CERTIFICA	ATE OF DEATH	Reg. Dist. No.
	1. PLACE OF DEATH OF COUNTY AND MARYLAND	2. USUAL RESIDENCE (Where deceased a. STATE	b. COUNTY (Art)
	or TOWN Illeviside corporate limits, write c. LENGTH OF STAY IN 16	c. CITY OR JOYAN III outside corpora	te limits write RURAL and give nearest town
	d MAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION	d. STREET ADDRESS	IS RESIDENCE ON A FARM? YES NO NO
	3. NAME OF DECEASED (Typegor print) Aidde (Typegor print)	Pale of DEATH	October 26 1958
	5. SEXT 6. COLON OF RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH	AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
	100. USUAL OCCUPATION (Give kind of profedone 100. KIND OF BUSINESS OR INDU Business of working life, even it betted)	STRY W. PINTHIPLACE (State or to eign con	12. CITIZEN OF WHAT COUNTRY?
-,4*	13. FATHER'S NAME / LONG Baughneran	14. MOTHER SMAIDEN NAME	
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes. no. for unknown) (If yes, give high or poles of service) 213-18-860 V	arl Boughan	ankaniche Ashalt
	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b); and (gl.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO	al Hemourh	INTERVAL BETWEEN ONSET AND DEATH ONSET AND DEATH
	Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	Musir	5 yris
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	NOT RELATED TO THE TERMINAL DISEASE	CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES NO 1
		D. (Enter noture of injury in Part I or Part I	of item 18.)
	20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED fa Hour a. m. 19 While Not while at work at work	ACE OF INJURY (Home, farm, 20f. (City o ctory, street, office bldg., etc.)	or town) (Caunty) (Stale)
	21. I certify that I attended the deceased fram Nov4	accurred at 3 A. M., fram	the causes and an the date stated above.
1	ACTUAL SIGNATURE WITH TOWARD	M.D. MANChe	s f e - Md 10 27-50
	PHYSICIAN'S NAME (Type) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1)	
	220. PUTHAL CREMATION, 22b. DATE THEREOF 22c. MAREOF CEMETERY O	Al Janus Dann	Cry., tolon, or equality Horle (s)
1	Frederick Bucker Hannes	DATEOCT 2 8 '58	ar 246. REGISTRAR'S SIGNATURE Orthur S. Kraus

VS A15 (4) 15M 9/55

	TE OF DEATH	CERTIFICA	With the same of t	
	- Latt County Day 2			
		The reason was	The second	
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en forest en bet trest, som en en best La la trest ette en best en en en best en Best en				
				100

11169 CERTIFICATE OF DEATH

11156 Reg. Dist. No.

	roll	MARYLAND	2. USUAL RESIDENCE (W o. STATE Mary)	h CC	institution: Residence bed	
b. CITY OR TOWN RURAL and give Union		write c. LENGTH OF STAY IN 16	c. CITY OR TOWN (IF	outside corporate limits.	write RURAL and give n	earest fawn)
OR INSTITUTION	PITAL (If not in hospital, give N View Conveles		d. STREET ADDRESS	Main Stree	et	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	First Effie	Middle Elizabet	h Belt	4. DATE OF DEATH OCT	Manth tober 15.	Day Year
5. SEX Female		MARRIED NEVER MARRIED DIVORCED DIVORCED	8. DATE OF BIRTH November 20	9. AGE (In last birt 88		AR IF UNDER 24 HRS
Oa. USUAL OCCUPATE during most of we Housewo:	orking lite, even it retired)	Own home	DUSTRY 11. BIRTHPLACE (Slote Marylar	or foreign country)		OF WHAT COUNTI
13. FATHER'S NAME	-3 W W		14. MOTHER'S MAIDEN			
	rles M. Hess	\$7 16. SOCIAL SECURITY NO. 17.	INFORMANT	eth Bushey	Address	
Yes, no. or unknown	(If yes, give war or dates of servi	ce]	rs. M. Ross Fa	ir, Taneyto		nd
Canditians, if gave rise to cause (a), statin lying cause las	immediate og the under-	Thronic Phronic	llegoes	ration	wited .	& year
PART 11. O	THER SIGNIFICANT COND	TIONS CONTRIBUTING TO DEATH B	UT NOT RELATED TO THE TERM	INAL DISEASE CONDITION	ON GIVEN IN PART 1(0)	19. WAS AUTOPS' PERFORMED? YES NO
200. ACCIDENT V OR CONTRIBUTION (IF EITHER, NOTIF	WAS UNDERLYING 120 NG 1 CAUSE OF DEATH FY MEDICAL EXAMINER)	b. DESCRIBE HOW INJURY OCCUR	RED. (Enter nature of injury in	Part 1 or Part 11 of item	18.)	
20c. TIME OF INJU	1.	20d. INJURY OCCURRED While Not while at wark at wark /	PLACE OF INJURY (Home, farr factory, street, office bldg., etc	n, 20f. (City or town)	(County	y) (Stote
21. I certify olive on	that attended the d		1938, 10 ft th occurred at 5 ft	M, from the cou		
PHYSICIAN'S NAME (Type)	SaLo	THER BARG				// //
220. BURIAL, CREMATI REMOVAL (Specif Burial	9) Oct. 18, 1	22c. NAME OF CEMETERY L958 Lutheran Ce		22d. LOCATION (City,	town, or county) n, Maryland	(State)
3. FUNERAL DIRECTO	Com Constant	ADDRESS			. REGISTRAR'S SIGNATI	
C.O.Fus	& Son, Tane	eytown, Maryland	DATE OF	CT 2 0 '58	Cirilar S. The	aus

be filed with ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page may be retained by the hispital ar attending physician.

TO FUNERAL DIR PR: After this certificate has been signed by the attending physician and campletely filled in by the page 3 should be retached far use as the burial-transit permit. Then please remave carban papers. Pages 1 and 2 state registrar prior to burial, cremation, ar remaval, and in any event within 72 hours after death. TO HOSPITAL OR

VS A15 (4) 15M 10/57 HTARO RO ETACHTIES CENTRACATE OR DEATH Tyree 1 radantilian b The section of the case (evac) well around Jacque while , we've Ecolo Delta Belt Belt Dotober 13, and out , is recently the control of the maniant Africana T seed . Me Tag 2 free coal, moreover, tenevis, tenevis, tene

Perial Cob. 18, 1968 Interna Cemptery Camertown, Sarving

C. W. Funne & Son, Tonortown, Larvience

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11170 CERTIFICATE OF DEATH

Reg. Dist. No. 11157

1. 8	Carroll			MARYL	AND	2. USUAL RESIDE o. STATE Maryla		ere deceased	b. COUNTY	on: Residen Balti	ce befor	re odmiss	ion)
t	CITY OR TOWN (If outside corporate lim	ils, write	c. LENGTH OF STAY I	N 16	c. CITY OR TO	WN (If o	ulside corpor	ate limits, write R	URAL ond	give nea	rest town	۱)
-	Sykesvill		give street	1 mo. 29 (days	Baltin d. STREET ADD	12.00	28,		035	2,	e. IS RES	
		eld State H	osni	tal		3 N. I	Beech	wood	Avenue				FARM?
3. 1	NAME OF		rst	Middle		last		4. DATE	Mon	th	Do	Y	Year
	Type or print)	Sarah		Elizabeth	B)	scklock		OF DEATH	Octob	er	24,		19 58
5. 5	EX	6. COLOR OR RACE	7. MAR	RRIED NEVER MARRIE	1	B. DATE OF BIRTH			9. AGE (In years last birthday)	IF UNDER Months			
1	Female	White	WIDOW		_	June 18.	187	72	86 yrs.	Months	Days	Hours	Min.
)0a.	USUAL OCCUPATION	ON (Give kind of work king life, even if retired	dane 10b	. KIND OF BUSINESS OF	INDUS	TRY 11. BIRTHPLAC	E (State	ar foreign co	untry)	12. CIT	IZEN O	F WHAT	COUNTRY
	Missiona					Marv	land			10	U.S.	A.	
13.	FATHER'S NAME					14. MOTHER'S M		IAME					
	Allen R.	Blacklock				Jane (Chamb	bers					
	WAS DECEASED EVE	R IN U. S. ARMED FOI		SOCIAL SECURITY NO.	17. 10	NFORMANT			Add	ress			
(Tes	no, or unknown)	(If yes, give war or dates of :		75-32-6456	Sr	ringfield	d Hos	mital	Records				
		ATH (Enter only one or	1 40	line for (a), (b), and (c).]	1	/* *** ***		JPE VOL	-10000		LINTE	RVAL BE	TWEEN
		TH WAS CAUSED BY:									ONS	ET AND	DEATH
	11000	IMMEDIATE CAUSE (AT	teriosclero	sis_	heart di	seas	0			V	ears	
	40.0	DUE TO											
	Canditions, if a)										
	gave rise to i												
	lying cause last.	The under-									40		
Z	PART II. OTI	HER SIGNIFICANT CON	IDITIONS	CONTRIBUTING TO DEA	TH BUT	NOT RELATED TO T	HE TERMI	NAL DISEASE	CONDITION GIV	'EN IN PAR	T 1(a) 1	9. WAS	AUTOPSY
ATIC				cerebral ar	_							DEDEC	DMEDO
CERTIFICATION	OR CONTRIBUTING	AS UNDERLYING CAUSE OF DEATH MEDICAL EXAMINER)	20b. DE	SCRIBE HOW INJURY OC	CURREC). (Enter nature of i	njury in P	Part 1 or Part	SYCHOLIC II of item 18.)	reac	T1 dr	מינט 🗆	140 [6]
	20c. TIME OF INJUR		or 20d	INJURY OCCURRED	20e. PL/	CE OF INJURY (Ho	me form	20f (City	or town)		County)		(State)
MEDI	Hour a.m. p. m.	19	While at wa	Not while	foc	tary, street, affice b	ldg., etc.)					
	21. I certify th	nat I attended the	decea	sed from Augus	t 25	19 58	to Oc	tober	24 19 58	that I	last sa	w the	deceased
	alive on Oct	1		58, and that									
	0		7)		acaiii	decorred digg			reet, city or town,		ile dui		ATE SIGNEE
	ACTUAL SIGNATURE	and s	Lus	than	/	A.D. Spri			ate Hosp	9-	10	/24/	
	PHYSICIAN'S NAME (Type)	Edmund Last	thaus	, M.D.		Syke	avil	le, Ma	ryland				
	BURIAL, CREMATIC			Greenmour	. 6	emetery		Balt	imore,	Mary]	land	(Stot	'e)
23.	FUNERAL DIRECTOR	'S SIGNATURE	7	- ADDRESS Ro	1	1 2	4a. REC'E	BY REGISTI	RAR 24b. REGIS	STRAR'S SIG	SNATUR	RE	
3	tarley Fr	w Home	reak	. T sonady No	02 1	esc.	ATOCT	31 '58	art	hun 8.	Krous	1	
	wuryou	NETTO IT	Cal	1/ 1	9-4	71	001			,,			

VS A15 (4) 15M 10/57

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11171 CERTIFICATE OF DEATH 11158

	A. A. A.	of other						Keg. Di	51. No.		
1. PLACE OF DEATH o. COUNTY Car	roll		MARYLA		o. STATE Mary	Vhere deceased	b, COUNTY	on: Residen		odmiss	sion)
b. CITY OR TOWN (If outside carporate lim	its, write	c. LENGTH OF STAY IN	1 1b	c. CITY OR TOWN (IF	outside corpo	rote limits, write R	URAL and	give near	est towr	1)
Sykesvil			Ly 2 m 9 d		Baltimore	18. M	d.	3V1	0/-	27	
	TAL (If not in hospital,	give stree			d. STREET ADDRESS					. IS RES	IDENCE
OR INSTITUTION	d State Ho	ani+	o T		2714 Guilf	ond Arre	anua			ON A	FARM?
3. NAME OF		ut abro			***************************************	4. DATE					
DECEASED (Type or print)	Arch	ie	Natanie:		Bowen	OF DEATH	10		Day 3		158
5. SEX		7. MAI	RRIED NEVER MARRIED	8. D	ATE OF BIRTH		9. AGE (In years last_birthday)	Months		Hours	ER 24 HRS.
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13. FATHER'S NAME				1	I. MOTHER'S MAIDEN						
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15. WAS DECEASED EVE	R IN U. S. ARMED FOI	RCES? 16	S. SOCIAL SECURITY NO.	17. INFO			Add	ress			
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200. ACCIDENT W. OR CONTRIBUTING	AS UNDERLYING [] G CAUSE OF DEATH MEDICAL EXAMINER)	20b. DE	SCRIBE HOW INJURY OCC								
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alive an	, , , , , , , , , , , , , , , , , , , ,	7 19	20, and that a	leath oc	curred direct		n the causes of treet, city or town,		he date		ed abav ATE SIGNE
ACTUAL SIGNATURE	found I	Lu	Mau	M.D.	Springfie						-L-58
PHYSICIAN'S NAME (Type)	Edmind I	nsth	aus M.D.		Sykesyi.l	Ja. Ma	ryland.				
220. BURIAL, CREMATIC	ON, 226. DATE THERE	OF	22c. NAME OF CEMETI	ERY OR CE			TION (City, town,			(Stot	le)
REMOVAL (Specify Burial	10/7/5	8	Cedar H	Hill		Bal	timore,	Md.			
23. FUNERAL DIRECTOR			ADDRESS		24a. REG	C'D BY REGIST		STRAR'S SIG	GNATURE		
JOHN F.	DENNY.	INC -	715 Light	St.	DATE O			Chur S.			
001111 1 .			Baltimore		Md.			J.	Heary	2	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DY STOR: After this certificate has been signed by the attending physician and campletely filled in by the page 3 shauld detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 the registrar prior to burial, crematian, ar remaval, and in any event within 72 hours after death. VS A15 (4) 15M 9/55

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MYASO TO STATE OF DEATH Alabara Senderah . 3.2 All Appropriate of Frusteeler A. M. albeitsmit Minnes V.

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours ofter death. If any delay is necessary please execute the certificate, writing the word "pending" in pencil in Item, 18. Give Pages 1, 2, and 3 to the Funeral director. Page 4 should be in reded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

TO FUNERAL D. CTOR: Page 3 should be used as a byrial-transit permit. File pages 1 and 2 with the State Both Health, or remarkal, and in any event within 72 hours ofter death. VS A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

111113

Reg.	Dist.	No.	

11160

	PLACE OF DEATH o. COUNTY	Carroll	MARYL	AND	2. USUAL RES	Marylar	-	. If institu				ision)
	b. CITY OR TOWN (I one give nearest town Syke svil.		5yrs.2mos.			Betheso		mits, write	RURAL and	give ne	arest for	vn)
-		al or institution (if no	of in hospital, give street address)		d. STREET A	5609 Re	oosevel	t St	•		ON	SIDENCE A FARM? NO.
	3. NAME OF DECEASED (Type or print)	Jane B	Middle Pattersor	1	CARNESE	OI OI		Moni		16,		9 58
	s. sex Female		MARRIED NEVER MARRIED		DATE OF BIRTH Februar		9. AGE fast br	(in years rihday) 7 yrs.	IF UNDER Months	-	Hours	R 24 HRS. Min.
	Housewife 13. FATHER'S NAME	ng life, even il refired)	10b. KIND OF BUSINESS OR IN		Scot	ACE (Slote or fore	eign country)			ZEN OF		COUNTRY?
	Samuel Pa	attercon				s Muir						
-	15. WAS DECEASED EV	ER IN U. S. ARMED FORCE		17, IN	FORMANT	5 Hull		Address				
1	No No	(If yes, give wer or dates of service	(0)		Spring	field He	ospital	Rec	ords			
	PART I. DEA 4-20 - / Conditions, if o gove rise to imme (a), staling the cause lost.	TH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Ony. which diote couse underlying DUE TO	Acute myocardi Coronary arter	rios	clerosi	3				Mi Ye	and dea inute	es
	9 bayenor	TO LEGGITOTI	ONS CONTRIBUTING TO DEATH	ebra	1 arter	ine terminal D	OSIS WI	th GIV	EN IN PART	T 1(a) 19.	PERFOI	RMED?
		USE WAS NTRIBUTING [] 206. D	ESCRIBE HOW INJURY OCCURR	IED. (En	ter nature of in	jury in Port I or P	Part II of item	18.)				
	20c. TIME OF INJU Hour v.m. p. m.	RY Manth, Day, Year 19	20d. INJURY OCCURRED 20e While Not while of work 0	PLACI factor	E OF INJURY (F y, street, affice	tome, farm, 20t bldg., etc.)	. (City or town)	(Cou	inty)		(State)
			the remoins described furol couses . Accidental Acciden		, Suicide		cide [],		Inquir ermined n	nanner	DATE SI	d in my
	Cremation	DN. 226. DATE THEREOF 10/20/58	22c. NAME OF CEMETER Cedar Hill	RY OR C	REMATORY		OCATION (C			ylar	(State)
	Robert A.		Bethesda, Md.			DATE OCT 2	EGISTRAR	24b. REGI	STRAR'S SIG	NATURE		

MARYLAND STATE DEPARTMENT DE MEASTHE-BALTIMORE, J.B.

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item, 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be in contacted to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files.

TO FUNERAL DI LIOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Bod Health, or its designated agent, prior to burial, cremation, ar removal, and in any great within 72 hours after death. 0

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11161 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

I tem 9 Film@235 11-3-58 et 11161 Reg. Dist. No.

1. PLACE OF DEATH O. COUNTY CARROLL COUNTY MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY
b. CITY OR TOWN (If outside carporate limits, write RURAL C. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest lown)
and give recreat lown) WESTMINSTER 35 IRS	127,
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS e. IS RESIDENCE
a. NAME OF HOSTINE OK HASTITOTION (II NOT III HOSPILLI, give sineer dooress)	ON A CARMO
	#10 WILLOW AVE. YES NO P
3. NAME OF DECEASED (Type or print) HARRY MONTROSE	CHEW DEATH 10 21/ 1958
5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED DIVORCED	8. DATE OF BIRTH GAPIEL 1, 1901 9. AGE (In years lost birthday) 57578 yrs. Months Days Hours Min.
10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUS during most of working life, even if retired)	
WESTERN MARYLAND RAVERDAD EMPLOYE	E FINKSBURG MD. U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
CHARLES CHEW	FANNY B. CHEW MEE!
15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17.	INFORMANT Address
	WIFE - MRS. MARK L. CHEW
18. CAUSE OF DEATH [Enter only one couse per-line for (o), (b), one (c).] PART I. DEATH WAS CAUSED BY:	Park 9. taus 9. interval between ones property
MAMEDIATE CAUSE (o)	rest forman orgeness fremels
DUE TO	
Canditions, if any, which) (b)	
gove rise to immediate cause (a), stating the underlying DUE TO	
couse fost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT	PERFORMED? YES NO PERFORMED?
200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b. DESCRIBE HOW INJURY OF CURRED. CAUSE OF DEATH.	Enter notice of injury in Port I or Port II or tem 18.)
3 20c. TIME OF INJURY Month, Doy, Yeor 20d. INJURY OCCURRED 20e. PL	ACE OF INJURY (Home, form, 201. (City or lown) Ory, treet/office bldg., etc.) (County) (State)
p. m. /0/2/ 1938 of work of work 2/45	· Keate 140 Westwunder Carrell mo
21. I certify that I taok charge of the remains described about	ove, held on Autopsy [], Inspection [X], Inquiry [], and in my
opinion death resulted from: Natural causes . Accident	
1112000	
SIGNATURE Willen Speller	M.D. CHIEF MEDICAL EXAMINER
SIGNATURE	ASSISTANT MEDICAL EXAMINER [7]
EXAMINER'S NAME (Type)	DEPUTY MEDICAL EXAMINER
1	
220 (BURIA), CREMATION, 22b. DATE THEREOF REMOVAL (Specify) BURIAL (0/25/58 BETH LL	CEMETER 22d. LOCATION (City, town, or county) (Stote)
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS & The	240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
Jame 19. Soffell & wastings at	12 Md DATOCT 2 4 '58
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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11174 CERTIFICATE OF DEATH Reg. Dist. No WATE directar 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 1. PLACE OF DEATH o. COUNTY filed b. COUNTY MARYLAND b. CITY OR TOWN (If autside carporate limits, write c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest lawn) c. LENGTH OF STAY IN 16 RUBAL and givernearest town) d. NAME OF HOSPITAL (If not in hospital, give street oddress) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION ON A FARM? East Main -ONGUIP YES NO W = NAME OF Middle 4. DATE Lost Month Day Year DECEASED DEATH (Type or print) 190 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS lost birthday) Months Days DIVORCED T WIDOWED papers. USUAL OCCUPATION (Give kind of work dane) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? death. during most of working life, ever if retired) and 4.5 A offer 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME physician acor 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (If yes, give wor or dates of service) 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (6) **DUE TO** Canditians, if any, which gove rise to immediate DUE TO couse (a), stating the under lying couse lost. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Day, Year 20d. INJURY OCCURRED (County) (State) foctory, street, office bldg., etc.) Not while Ma at work of work TOME 21. I certify that I attended the deceased fram A,that I last saw the deceased and that death accurred at 8157/M, from the causes and an the date stated above. alive an Co OR ADDRESS (Street, city or SIGNATURE prid ā D PHYSICIAN'S NAME (Type) 3 shau FUNERAL 22b. DATE THEREOF 220. BURIAL CREMATION. 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) page Md. REMOVAL (Specify) ct.11,1958 the St. Joseph's Catholic Emmitsburg. 0 FUNERAL DIRECTOR'S SIGNATURE 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE arthur S. Krous Emmitsburg, Md. VS A15 (4) DATE OT 1 4 158 15M 9/55 ison

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11175

CERTIFICATE OF DEATH

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1. PLACE OF DEATH o. COUNTY Ca	rroll		MARYLAND	2. L	STATE Mai	there deceased	L COUNTY		e before adm	ission)
b. CITY OR TOWN (I RURAL and give no Sykesvil	f autside carporate limits, arest tawn)		6. LENGTH OF STAY IN 16		E. CITY OR TOWN (IF			RAL and gi	ve nearest to	wn) V
d. NAME OF HOSPIT OR INSTITUTION Springfi	AL (If not in hospitol, give eld State Ho	street oo	ddress) al		d. STREET ADDRESS 3438 ET	lmora A	ve.		ON	ESIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	Ida C	irace	Middle Thompson	Dav	lost 'ey	4. DATE OF DEATH	October		Day 7,	Yeor 19 58
s. sex Female	4 50 A 5	MARRIE	D NEVER MARRIED DIVORCED		pt. 25, 18	871		F UNDER 1	YEAR IF UN Days Haur	IDER 24 HRS. Min.
10o. USUAL OCCUPATION during most of war Housewif	ung lite, even it retired)	ne 10b. K	IND OF BUSINESS OR INDU	STRY	11. BIRTHPLACE (Store Maryland	or foreign ca	untry)	12. CITI2	U.S.A	AT COUNTRY?
13. FATHER'S NAME				14.	MOTHER'S MAIDEN	NAME				
Andrew T	hompson Whe	eler			Laura Jos	sephine	-Mackhei	mer		
15. WAS DECEASED EVE [Yei, no or unknown)	R IN U. S. ARMED FORCE (If yes, give war or dates of servi	S? 16. S(pri	mant ngfield Ho	ospital	Addres Records	5		8
Conditions, if a gove rise to it couse (o), stating lying couse last.	m mediate the under- (c)_		terioscleroti				CONDITION GIVEN	N IN PART		ars
20a. ACCIDENT WA			I arcertoscle		~			n,	YES [
20c. TIME OF INJUR Hour o. m. p. m.	Y Month, Doy, Year 19	20d. INJ While of work	Not while far	ACE O	PF INJURY (Home, forestreet, office bldg., etc.	m, 20f. (City (ar town)	(Co	ounty)	(State)
actual Signature	www Le	1958	eau	acci	Springfie	M, from ADDRESS (Street	the causes and eet, city or town, sto te Hospit	d an the	e date sta	e deceased ated abave DATE SIGNED /8/58
INAME (Type)	Edmund Lustl	naus,			Sykesvil:					
BURIAL (Specify)	10-10-58		22c. NAME OF CEMETERY O Loudon Park		MATORY		ON (City, town, or timore	county)	(\$1	ote)
23. FUNERAL DIRECTOR		17 9	ADDRESS	s t.		D BY REGISTR		RAR'S SIGH	1 .	

VS A1S (4) 1SM 9/S5

MARYLAND STATE DEPARTMENT OF HEALTH-BASTIMORE, 18

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CERTIFICATE OF DEATH

Reg. Dist. No.

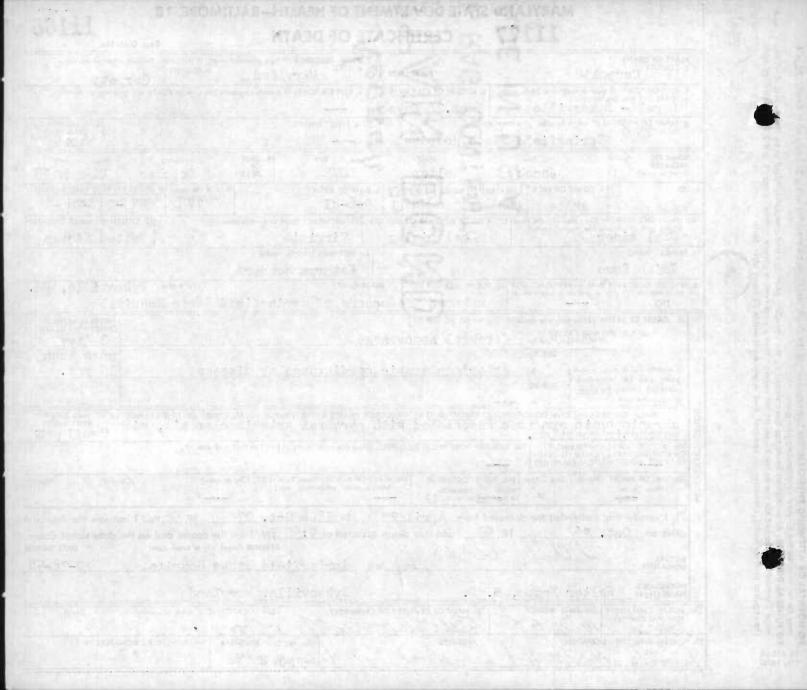
							Mad. Dist.	110.	
1. PLACE OF DEATH				2. USUAL RESIDENCE	(Where deceased	lived. If institution b. COUNTY	on: Residence	before admir	ssion)
Ca	rrell		MARYLAND	Ma	ryland	b. CO01411	Cit	V	
b. CITY OR TOWN (I	If outside corporate lim	its, write c. LE	NGTH OF STAY IN 16	c. CITY OR TOWN	(If autside carpor	rate limits, write R	JRAL and giv	re nearest tow	vn)
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	TAL (If not in haspital, s			d. STREET ADDRES				e. IS RE	SIDENCE A FARM?
	eld State	Hospital		1520 Belt	Street				NO D
3. NAME OF	fi		Middle	last	4. DATE	Man	th	Day	Year
(Type ar print)	Harr	Y	Foseph	Dixon	OF DEATH	10		4(4)	19 58
S. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	10-11-11	9. AGE (In years		YEAR IF UND	DER 24 HRS.
Male	W	WIDOWED	DIVORCED	9-27-90		last birthday)	Months D	Days Haurs	Min.
00. USUAL OCCUPATIO	ON (Give kind af wark	dane 10b. KIND	OF BUSINESS OR IND	USTRY 11. BIRTHPLACE (S	state or foreign ca		12. CITIZ	EN OF WHA	T COUNTRY
during most of worl	king life, even if refired)							
3. FATHER'S NAME	DEK			Mary s			_ U	S.A.	
S. TATTIER S TYPINE				14. MOTTER 3 MAID	EIN INAME				
Reber	t Joseph D	ixon		Maria Mc	Nanee				
5. WAS DECEASED EVE	R IN U. S. ARMED FOR		AL SECURITY NO. 17.	INFORMANT		Addr	033		
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C D Per II. QT			IBUTING TO DEATH BL	NOT RELATED TO THE T	ERMINAL DISEASE	CONDITION GIV	EN IN PART 1	(a) 19. WAS	AUTOPSY
Pulmonary	tuberoule	r unspec	cau	se with psyc	en. react	cion		PERF	ORMED?
200 ACCIDENT W	S TINDEBLAING L	STR HOUSE	HOW INTERA OCCUR	anced inacti	v in Port I at Part	II of item 18.1		11.3	1 110 10
OR CONTRIBUTING	AS UNDERLYING CONTROL CAUSE OF DEATH MEDICAL EXAMINER)	200. DESCRIBE	002X	CD. (Enter nature at injury	y in roll I di roll	n or nen re.,			
	Y Month, Day, Ye		OCCUPPED 200 5	PLACE OF INJURY (Hame,	fmem 206 (City		10		150.1.1
20c. TIME OF INJUR Haur o. m. p. m.			Nat while f	actory, street, affice bldg.	, etc.)	or igwnj	(Cai	unty)	(State)
p. m.	19		at work						
21. I certify th	at I attended the	deceased fr	om 3-27	- 19 57, to	10-3-	19.58	that I la	st sow the	decense
glive on 10-				h occurred of 13	3A M 6	Abo onuses		- d-44-	A al alas
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SIGNATURE	viney (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		M.D. Springf	1610 Sta	te Hespi	tal		0-4-58
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NAME (Type)	Edmind Lus	thaus M.	D	Sylvasy	Lle Mar	ryland			
220. BURIAL, CREMATIC		OF 22c.	NAME OF CEMETERY			ION (Gity, tawn,	or county)	(Sto	ote)
REMOVAL (Specify)	10/7/19	58	Calleda	cal	13	alto)	rel.		100
23. FUNERAL DIRECTOR			ADDRESS	1 24	REC'D BY REGIST	PAR 245 PEGIS	TRAR'S SIGN	JATURE	
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TO FUNERAL DIPPORTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should. Netached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 d be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 haurs after death. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours ofter death. Page 4 VS A15 (4) 15M 9/55

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VS	TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the filled with the registrar prior to burial, cremation, ar remayal, and in any event within 72 hours after death.	
15/	M 10/57	

		The state of the s					Reg. Dis	t. No.
1. PLACE OF DEATH o. COUNTY Car	roll	MARYLA	- 11	o. STATE Mary	Where deceased	d lived. If instituti b. COUNTY	~	e befare admission)
RURAL and give r	(If outside corporate fimils, where the state of the stat	5mos . 28 day		c. CITY OR TOWN (If outside corpo	rote limits, write R		ive nearest town)
d. NAME OF HOSPI OR INSTITUTION	Springfield	reer oddress) State Hospital		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	First Jacob	Middle Walter		DOVE	4. DATE OF DEATH	Mor Octo	ober	Day Year 27 19 58
s. sex male		MARRIED NEVER MARRIED DOWED DIVORCED		-6-81		9. AGE (In years last butbaday) yrs.		YEAR IF UNDER 24 HRS. Days Hours Min.
100. USUAL OCCUPATI during most of wor Coal min	king life, even if refired)	Coal minir		Virginia		ountry)		ZEN OF WHAT COUNTRY
Isiah Do	ve		1.	Kathryn S				
1S. WAS DECEASED EV (Yes, no or unknown)	ER IN U. S. ARMED FORCES? (If yes, give wor or dates of service		Reco	rmant rds of Spr	ringfie.			esville, Md.
	ATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO ony, which (b) immediate (CAUSE B)	per line for (o), (b), and (c).] Cerebral hemore		Maria A	ılar di:	sease		interval Between onset and Death 3 days more than 15 yrs.
PART II. OT Chronic DSychoti 20. ACCIDENT W. OR CONTRIBUTION (IF EITHER MOTIFY 20c. TIME OF INJUI	HER SIGNIFICANT CONDITION DE AID SYNCTON C PEACTION G CAUSE OF DEATH MEDICAL EXAMINER) RY Month, Day, Year 2	DNS CONTRIBUTING TO DEATH LE ASSOCIATED W DESCRIBE HOW INJURY OCCU Od. INJURY OCCURRED 20 While Not while	JRRED. (E	cerebral a	in Port I or Port	II of item 18.)	s, wit	h 19. WAS AUTOPSY PERFORMED? YES NO 🖾
actual SIGNATURE	nat I attended the dec	ceased from April 19.58, and that de	eath ac		PM, from ADDRESS (S)	the causes of the town, ate Hospi	ind on the state)	
NAME (Type)	Walter Knopp,							



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ENDING PHISICIAN:	the hospitol or ottendin	OR: After this certificate	etoched for use os the b	buriol, cremation, or r
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OK ALIENDING PHISICIAN:	ned by the hospitol or ottendin	JOR: After this certificate	date of the design of the b	prior to buriol, cremation, or r
AL OR ALLENDING PHISICIAN:	etained by the hospitol or ottendin	AL DIPERTOR: After this certificate	hould detoched for use os the b	or prior to buriol, cremation, or r
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I CHOSTIAL OR ALIENDING PRINCIAN: The faw requires that the depth certificate be executed within 24 ha	moy be retained by the hospitol or ottendin	TO FUNERAL DIPORTOR: After this certificate has been signed by the attending physicion and completely filled in	ವಿತ್ತ page 3 should detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 ar	the registror prior to buriol, cremation, or r

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death: Poge 4

				CERT	IFICA	CIE OF L	PEAIL	1			Reg. D	ist. No		
	COUNTY Ca	rroll		MAI	RYLAND	2. USUAL RESIL	DENCE (Wh	nd		institution OUNTY		nce befo	re odmiss	ion}
ь.	CITY OR TOWN (I	If outside corporate linearest town)	nits, write	2 mths 1		c. CITY OR T		14,		write RU	IRAL and	give nec	orest lown)
d.	NAME OF HOSPIT OF INSUTUTION Spring!	TAL (If not in hospital, eld State	give street Hospi	oddress) tal		d. STREET A 2914	Joppa	Road					e. IS RES	FARME
DE	VME OF CEASED 'pe or print)	_	ini ırah	Eliz:	abeth	Guer	-	4. DATE OF DEATH		Month 10	h	3))	1,58
. SEX	F	W	WIDOW		ED 🔲	7- 10	-67		9. AGE (In	h years thdoy) yrs.	Months	R 1 YEAR Days	Hours	R 24 HRS Min.
Oo, L	JSUAL OCCUPATION IN THE PROPERTY OF WORLD	ON (Give kind of work king life, even if retire fe	done 10b.	KIND OF BUSINESS	OR INDUS		land	or foreign c	auntry)			U.S.	A.	COUNTR
3. FA	Daniel	Joyner				14. MOTHER'S	MAIDEN N							
		R IN U. S. ARMED FO (If yes, give war or dates of		social security N		S.Hospi	tal R	ecord	s	Addre	955			
		mmediate the <u>under-</u>	o Art	ne for (a), (b), ond (c terioscler		cardiova	ascula	ar dis	ease			ONS	ERVAL BE SET AND Tears	DEATH
	C.B.S.	HER SIGNIFICANT CO									N IN PA	RT 1(a) 1		AUTOPSY RMED? NO
) (E	F EITHER, NOTIFY	AS UNDERLYING CONTROL CAUSE OF DEATH MEDICAL EXAMINER) Y Month, Day, Y		CRIBE HOW INJURY		CE OF INJURY				18.)				15.
M. C.	Hour a.m. p. m.	19	While of wor	_ Nat while _	fact	lary, street, office	bldg., etc.)		58		(County)		(Stote
A SI	1. I certify the slive on 10 CTUAL SAME (Type)	eat I attended the control of the co	19 Lu	58, and the	at death	n.U	ingfie	M, from	n the ca treet, city o cate H	uses ar r town, s lospi	nd an I			ed abay
CR	URIAL) CREMATIO	10-8-		22c. NAME OF CE	METERY OR	CREMATORY		22d. LOCA	TION City.	town, or	county)	m	Stote	e)
J. FU	emach	SSIGNATURE)	1 5	305 Ha	enfo	vel.	240. REC'D	7 '58		a. REGIST				

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11179 CERTIFICATE OF DEATH

11168

	~~~	544	CERTI	FICAI	E OF DEAT	П		Reg. D	ist. No.		
-	ARROLL		MARY		USUAL RESIDENCE (	Where deceased	b. COUNTY	an: Reside	nce befo	re admis	sion)
b. CITY OR TOWN RURAL ond give	(If outside corporate limit nearest town)  *Svkvsvil]	s, write	c. LENGTH OF STAY	IN 1b	c. CITY OR TOWN (I		rate limits, write RI esville	URAL ond	give nec	rest tow	n)
	PITAL (If not in haspital, a				d. STREET ADDRESS	Mill I				e. IS RES	SIDENCE A FARM?
3. NAME OF DECEASED (Type or print)	Fin DALE	st	Middle ALLEN	HAV	Lost WKTNS	4. DATE OF DEATH	Man OCT	th 2	Do		Year 19 58
s. sex male	6. COLOR OR RACE	7. MARR	ED NEVER MARRIE	423	ATE OF BIRTH	56	9. AGE (In years last birthday) 2 yrs.	Months	Days		ER 24 HRS. Min.
10a. USUAL OCCUPAT during mast of we NON	ION (Give kind of work or brking life, even if retired)	lane 10b.	KIND OF BUSINESS O	R INDUSTRY	Maryla		ountry)		S.	F WHAT	COUNTRY
13. FATHER'S NAME	W. LeRoy	Haw	kins	1	A. MOTHER'S MAIDEN		ray				
1S. WAS DECEASED EN (Yes. no. or unknown)	/ER IN U. S. ARMED FOR (If yes, give wor or dates of se	rvice)	social security no	1	rmant - LeRoy Ha	wkins	Addr Same	ess			
Conditions, if gave rise to couse (a), statinglying cause last	g the under-		rach	usk	el sr	ulf			2	ET AND	and
20g. ACCIDENT V OR CONTRIBUTION (IF EITHER, NOTIF	GALCAUSE OF DEATH Y MEDICAL EXAMINER)  URY Month, Day, Yea	20b. DESC or 20d. Ib	CRIBE HOW NJURY OF	CCURRED AF	nter pause of injury inter pause of injury interpretation of injury injur	in Port by Post	A	poke	RT 1(0) 1	PERFC YES [	AUTOPSY ORMED? NO XI
	that Vattended the	ar wers	100	death or	curred at 21/3			nd an	last so	w the	deceased ed abave
22a. BURIAL, CREMATI REMOVAL (Specif	10-27-		Deer E		:	Bal	ION (City, town, o	Mar			(e)
23. FUNERAL DIRECTO	Waltz,	Win	ADDRESS field. Ma	ryla	- 3	C'D BY REGIST		TRAR'S SI	4 .		

DATE OCT 2 7 '58

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRPTOR: After this certificate has been signed by the attending physician and campletely filled in by the page 3 should set stacked for use as the burial-transit permit. Then please remanaration papers. Pages 1 and 2 stake registrar prior to burial, cremation, ar remaval, and in any event within 72 habrs after death. VS A15 (4) 15M 9/55

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11163

### CERTIFICATE OF DEATH

Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. COUNIX b. COUNTY MARYLAND b. CITY OR TOWN (If outside carporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If autside carporote limits, write RURAL and give nearest tawn) RURAL and give negrest town) d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES NO Z 3. NAME OF Middle 4. DATE Month Yeor DECEASED DEATH (Type or print) / 19. IF UNDER 1 YEAR IF UNDER 24 HRS 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In years lost birthdoy) Months Doys Hours WIDOWED IZ DIVORCED T 10o. USUAL OCCUPATION (Give kind of wark dane dubing most of warking life, even if retired) 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME 17. INFORMAN 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 18. CAUSE OF DEATH [Enter only one cause per line for (b), (b), and (c).] INTERVAL RETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) DUE TO Canditians, if any, which gave rise to immediate DUE TO coese (o), stoting the underlying couse last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(p) 179. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month. 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (Stote) foctory, street, affice bldg., etc.) Hour a.m. While Not while p. m. of work of work 21. I certify that I attended the deceased from 1900, that I last saw the deceased alive on Q and that death occurred at 1 / 2 / My from the causes and on the date stated above. DATE SIGNED ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) 22a. BURIAL, CREMATION. 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (State) REMOVAL (Specify) **EUNERAL DIRECTOR'S SIGNATURE** ADDRESS 246. REGISTRAR'S SIGNATURE 240. REC'D BY REGISTRAR Circhan S. Thous OCT DATE

0 VS A15 (4) 15M 9/55

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may be retained by the haspital ar attending physician.

O FUNERAL DIFF OR: After this certificate has been signed by the attending physician and campletely filled in by the page 3 shauld as yetached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 2 state registrar priar to burial, crematian, ar remaval, and in any event within 72 haurs after death.

TO FUNERAL DIF TO HOSPITAL OR

VS A15 (4) 15M 10/57

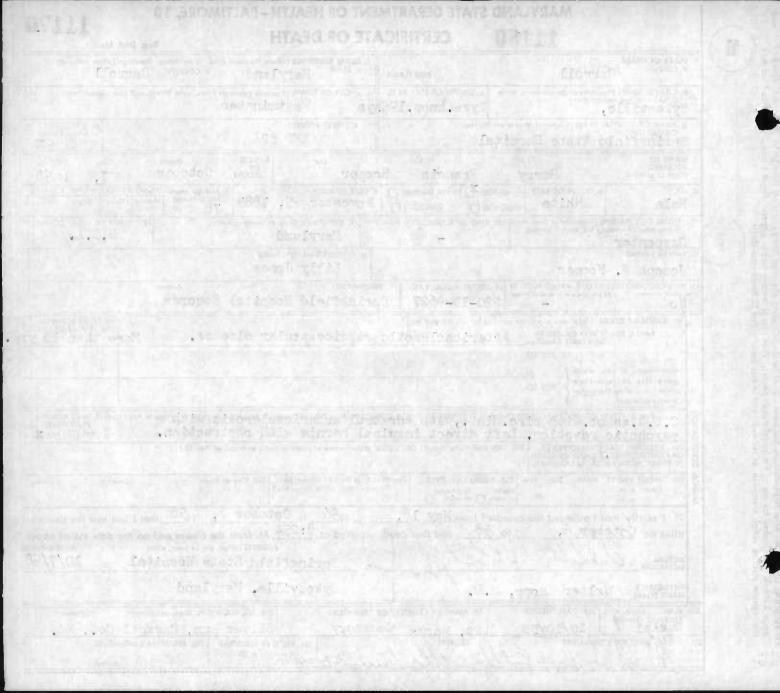
# MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

**CERTIFICATE OF DEATH** 

11180

11170

	ally ally pic U					
o. COUNTY	arroll	MARYLAND	2. USUAL RESIDENCE (WI	here deceased lived. If institution b. COUNTY	on: Residence be	
b. CITY OR TOWN (If RURAL ond give nec	outside corporate limits, writarest town)	c. LENGTH OF STAY IN 16  2yrs. Lmos. 19d		outside corporate limits, write RI minster	URAL ond give n	earest town)
OP INSTITUTION	d State Hospi		d. STREET ADDRESS / RFD	#2		e. IS RESIDENCE ON A FARM? YES NO
NAME OF DECEASED (Type or print)	First Harry	Middle Francis H	ooper	4. DATE Mon Octobe		7. Year
SEX Male	Tithe 4 + a	ARRIED NEVER MARRIED DWED DIVORCED	8. DATE OF BIRTH November 25,	9. AGE (In years lost birthdoy) 74 yrs.	Months Days	AR IF UNDER 24 HR Haurs Min.
during most of working Carpenter	N (Give kind of work done I ng life, even if retired)	06. KIND OF BUSINESS OR INDU	Maryland			S.A.
Joseph F.	Hooper		Lilly Jo			
	IN U. S. ARMED FORCES? I yes, give wor or dates of service)		pringfield Ho	ospital Records		
PART 1. DEAT	DUE TO	r line for (a), (b), ond (c).] rteriosclerotic	cardiovascul	ar disease.	0	than 10
PART I. DEAT  42. I  Conditions, if on gove rise to in cause (o), stoting it lying couse lost.	H WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  y, which the under- the under- ER SIGNIFICANT COMPUTION	•	DPH1:^#1-69-61-6-6-	vidhenoresong	More	19. WAS AUTOPS
PART I. DEAT  LA A. I  Conditions, if on gove rise to im cause (o), stoting II tying couse lost.  C. BAS ass psychotic  20a. ACCIDENT WAS OR CONTRIBUTION (IF EITHER, NOTIFY A	H WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  y, which he under-  ES SIGNUSCANI CONDUITO  CO  TES CONTROL CONDUITO  S UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	SCONTRIBUTUNE TO DEATH WE STEEL STORY OF THE PERSON OF THE	DryllAgreer1608 nal hernia wi	th obstruction	More Ven in part 1(o)	19. WAS AUTOPS PERFORMED? YES \( \) NO \( \)
PART I. DEAT  LA A. I  Conditions, if on gove rise to im cause (o), stoting II lying couse lost.  C. BAS 835  DSYCHOTIC  20a, ACCIDENT WAS OR CONTRIBUTING (IF EITHER, NOTIFY A Hour a. m. p. m.	H WAS CAUSED BY: IMMEDIATE CAUSE (o)  DUE TO  y, which he under  ER SIGNIFICANT COMOTION  COLUMN COMOTION  TO COMOTION  TO COMOTION  TO CAUSE OF DEATH  MEDICAL EXAMINER  Month, Day, Year  Wool	NET CONTRIBUTION TO PEATH RUE  STEP CONTRIBUTION TO PEATH RUE	DANIA TREMITOR MINISTRATION OF INJURY (Home, form clary, street, office bldg., etc.)	th obstruction Port I or Port II of item 18.)  n,   20f. (City or town)	More VEN IN PART I(o)	19. WAS AUTOPS PERFORMED? YES NO 1
Conditions, if on gove rise to im cause (o), storing it lying couse lost.  C. Bos eass psychotic conditions of the contribution of the contributio	H WAS CAUSED BY: IMMEDIATE CAUSE (e)  DUE TO  y, which he under- the under- ER SIGNIFICANT COMPUTED  TO COMPU	Arteriosclerotic	nal hernia wi D. (Enter nature of injury in  ACE OF INJURY (Home, form clary, street, office bldg., etc., 1956 to 00  accoursed at 8:256  M.D. Springf:	th obstruction Port I or Port II of item 18.)  n,   20f. (City or town)	(Count that I last and an the distate)	19. WAS AUTOPS PERFORMED? YES NO 1



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MARYLAND	STATE DEPARTMENT	OF HEALTH—BALTIMORE,	18
1118	1 CERTIFICATE	OF DEATH	

CERTIFICATE OF DEATH

11171

					R	leg. Dist. h	No.	
1, PLACE OF DEATH 6. COUNTY Carroll		MARYLAND	2. USUAL RESIDENCE (M o. STATE Maryland	Where deceased li	b. COUNTY	Residence b		ssion)
b. CITY OR TOWN (If outside corporate lin RURAL and give nearest town)  Henryton	nits, write	c. LENGTH OF STAY IN 15	Annapolis		le limits, write RUR	AL and give	nearest tov	'n) V
d. NAME OF HOSPITAL (If not in hospital, OR INSTITUTION			d. STREET ADDRESS		. 0 8	10.0	ON	SIDENCE A FARM?
Henryton State Hosp	Ital		II 4/ N. Wes	st Stree	t		AF2 [	] NO 💆
P. NAME OF DECEASED (Type or print) Menthe	olia	Middle	Jones	4. DATE OF DEATH	October		Day	Year 19 58
SEX 6. COLOR OR RACE  Female Negro	7. MARK	NED NEVER MARRIED DIVORCED	8. DATE OF BIRTH 2-10-1925	9.		UNDER I YE		-
0a. USUAL OCCUPATION (Give kind of work during most of working life, even if retire Unknown	done 10b		USTRY 11. BIRTHPLACE (STOR	te or foreign cour	ntry)	12. CITIZEN	S. A	T COUNTRY
3. FATHER'S NAME			14. MOTHER'S MAIDEN	NAME				
Irvin James	•		Esther	Lomax				
(Yes, no. or unknown)  No	service)		INFORMANT Mentheolia Jo	nas	Address	lest St	treet.	
gove rise to immediate couse (o), stating the <u>under-lying cause lost.</u>	Tu	berculoma of berculous Men	ningitis	MINAL DISEASE C	ONDITION GIVEN	IN PART 1(o	ille was	AUTOPSY
Ž							PERF	ORMED?
	20b. DESC	CRIBE HOW INJURY OCCURR	ED. (Enter noture of injury in	Port I of Port II	of item 18.)			
20c. TIME OF INJURY Month, Doy, You Hour o. m. 19	20d. It While of work	Not while for	LACE OF INJURY (Home, for octory, street, office bldg., et		town)	(Count	(y)	(Stote)
21. I certify that I attended the alive on October 3.  ACTUAL SIGNATURE  PHYSICIAN'S Dr. E. M. M.	, 19	58, , and that deat	h accurred at 2:05	AM, from ADDRESS (Street yton, Ma	the causes and et, city or town, state aryland	d an the c	date stat	ed above ATE SIGNE -3-58
220. BURIAL, CREMATION, 22b. DATE THERE REMOVAL (Specify) 22b. 10-7-		22c. NAME OF CEMETERY OF Brewer			ON (City, tawn, or c		(Sto	rylan
23. FUNERAL DIRECTOR'S SIGNATURE	K=7	ANNA PO	L 15-Ma DATE 0	CT 8 '58		AR'S SIGNAT		

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### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

11182 Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. county rrol o. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) rural -- Finksburg rural-Finksburg VIS d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS e. IS RESIDENCE OR INSTITUTION at Gamber YES NO 3. NAME OF First Middle 4. DATE DECEASED OF DEATH OCT. 1958 (Type or print) 15 6. COLOR OR RACE 9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED NEVER MARRIED | 8. DATE OF BIRTH Months Days Hours DIVORCED T WIDOWED | male -25-1902 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) shoe stitcher shoe factory Maryland U.S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Walter L. Jordan Anna Elizabeth Parrish 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Hilda Jordan. no Same 18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH failure, Arteroscleratic Heart Dis, PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) DUE TO It Lung ATtectasis, Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. CERTIFICATION PERFORMED? YES NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, form, 20f. (City or town) 20d. INJURY OCCURRED Doy, Year (County) (Stote) factory, street, office bldg., etc.) Haur a. m. While Not while of work at work p. m. 1958 that I lost saw the deceased 21. I certify that I attended the deceased from and that death occurred at 9:00P M, from the causes and on the date stated above. alive on_ ADDRESS (Street, city or, town, state) ACTUAL SIGNATURE PHYSICIAN'S HOWARD E. HALL NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) (Stote) 10-19-1958 Mt.Pleasant Gamber. 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24b. REGISTRAR'S SIGNATURE 24o. REC'D BY REGISTRAR Winfield, Md. C. M. Waltz. Luming & Theated

DATE

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TARREST CONTRICATE OF DEATH Remark the responsibility of the follow to the site of the second of the

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#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18 11183

**CERTIFICATE OF DEATH** 

11173 Pen Dist No

					Kag. Dist. 140.
1. PLACE OF DEATH o. COUNTY Carrol	1	MARYLAND	o. STATE	- b COUNTY	iani Residence before admission)  Allegany County
b. CITY OR TOWN (If autside co RURAL and give nearest town) Sykesville	rporate limits, write	1 mo. 3 days	c. CITY OR TOWN (IF	outside corporate limits, write I	
d. NAME OF HOSPITAL (If not in OR INSTITUTION Springfield St	hospitol, give stree ate Hospi	t oddress)	d. STREET ADDRESS None		Is residence     On a farm?     Yes    No    N
3. NAME OF DECEASED (Type or print)	First Credy	Middle	KERLEY lost	4. DATE MOI OF DEATH OCTOB	
S. SEX 6. COLOR Whi		RRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH October 12,	1878 9. AGE (In years lost birthday) 79 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kinduring most of working life, even Railroad work	en if retired)	Railroad	Unknown		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN Unknown		
15. WAS DECEASED EVER IN U. S. / [Yes. no. or unknown] (If yes, give wo	ARMED FORCES? 16 or or dates of service)		INFORMANT Springfield Ho	spital Records	dress
1B. CAUSE OF DEATH (Enter PART 1. DEATH WAS CAUMMEDIAT 521 X Conditions, if any, which gave rise to immediate	AUSED BY: E CAUSE (a)  DUE TO  (b)	line for (a), (b), and (c).] Abscess of li	ung		INTERVAL BETWEEN ONSET AND DEATH Weeks
cause (a), stating the underlying cause last.  C. B. PAST II. OTHER SIGNIFE  C. B. S. BESSOC. WI  200. ACCIDENT WAS UNDERLY OR CONTRIBUTING   CAUSE (IF EITHER, NOTIFY MEDICAL E	ING [] 20b. DE		ULTNOT PELATED 10 THE TERM PS		VEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES MO
20c. TIME OF INJURY Month, Hour a.m. p. m.	Whil		PLACE OF INJURY (Hame, far factory, street, affice bldg., et		(County) (Stale)
21. I certify that I atterdate on October 8  ACTUAL SIGNATURE ACTUAL SIGNA		58, and that dea	th accurred at 8:45  M.D. Springfi	Address (Street, city or town, eld State Hosp	4- 4.40
	ATE THEREOF			22d. LOCATION (City, town,	or county) (State)
23. FUNERAL DIRECTOR'S SIGNATU	re wan fed	on Ball	2. 7.	7CT 0 '59	Inthur & f

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#### MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11184

**CERTIFICATE OF DEATH** 

11174 Rea Dist No.

								MAA. DISI	. 110.	
I. PLACE OF DEATH	17		MARYLA		USUAL RESIDENCE (		d lived. If institution b. COUNTY			lmission)
Car					Mary Mary			Carro		
RURAL and give	(If outside corporate limits, nearest town)	write	c. LENGTH OF STAY IN	1 15	c. CITY OR TOWN (	If outside corpo	prote limits, write R	URAL ond give	re nearest	town)
Deto			1 vears	X	Detou	129				
d. NAME OF HOSP	ITAL (If not in hospital, give	e street	address)	1	d. STREET ADDRESS	41			10.10	RESIDENCE
OR INSTITUTION				1/	O. STREET ADDRESS				0	N A FARM?
									YE	NO D
3. NAME OF	First		Middle		Lost	4. DATE	Mon		Day	Year
(Type or print)					6031	OF			Day	reur
	James 1					DEATH	October	6.		19 58
5. SEX	6. COLOR OR RACE 7	- MARR	IED NEVER MARRIED	□ B. D	ATE OF BIRTH		9. AGE (In years		YEAR IF U	NDER 24 HRS.
Male	White	VIDOWE	DIVORCED	П О-	1.1 0/	70/0	last birthday)	Manths D	ays Ho	urs Min.
	11 11 11 10 0			- loc	tober 26,	1909	89 угз.			
during most of wo	ION (Give kind of work do rking life, even if retired)	ne IUb.	KIND OF BUSINESS OR	INDUSTRY	11. BIRTHPLACE (Sto	ate or foreign o	ountry)	12. CITIZ	EN OF W	HAT COUNTR
Farmer		0	wn farm		Maryland	1		TT	S.A.	
3. FATHER'S NAME		1 0	WII LOUIN	li.	. MOTHER'S MAIDEN			U	D.R.	
				-	. MOTHER 3 MAIDER	4 IAWWE				
James	Kiser				Alice	Rowe				
S. WAS DECEASED EV	ER IN U. S. ARMED FORCE		SOCIAL SECURITY NO.	17. INFO		3.4.1.9	Addr	ess		
(Yes, no, ar unknown)	(If yes, give war or dates of serv	ice)								
NO			None	Mrs	. Carroll	Doughe	rty De	tour.	Md.	
18. CAUSE OF DE	ATH [Enter only one caus	e per lir	ne far (a), (b), and (c).]						INTERVA	L BETWEEN
PART I. DE	ATH WAS CAUSED BY:	An	tentocolor	natt	Wanni 7	04				ND DEATH
	IMMEDIATE CAUSE (a)_	AI	terioscle	COLT	neart I	viseas	0		TC	year
420.0	DUE TO									
Conditions, if	ony which )	Get	neralized	Ante	ningala	neate			10	LDT 4 11 2
gave rise to	immediate (	-0.	TOT WATEOU	111 00	TOPOTO	LOSTS			15	years
cause (o), stoting	the under-									
lying cause last	_ (c)_									
PART II. OT	THER SIGNIFICANT CONDI	TIONS C	ONTRIBUTING TO DEATH	H BUT NOT	RELATED TO THE TER	MINAL DISEAS	E CONDITION GIV	EN IN PART	(a) 19. W	AS AUTOPSY
									PE	RFORMED?
	c Arterios	CT6	rotic Neph	riti	s. Cerel	oral H	emorrha	ge_	YES	□ NO 🔀
→ 1 200. ALLIDENT W	AS UNDERLYING 1 1 20	Ob. DESC	CRIBE HOW INJURY OCC	URRED. (E	nter nature of injury i	in Part I or Par	t It of item 18.)	0-		
(IF EITHER, NOTIF	G CAUSE OF DEATH									
	RY Month, Day, Year	204 11	NJURY OCCURRED 20	De BLACE	OF INTERPORT	000 451				
20c. TIME OF INJU		While	_ Not while_	factory,	OF INJURY (Home, for	orm,   201, (City	or tawn)	(Co	unty)	(State)
p. m.	19	at work	at work							
			E 03	10		30 0	50			
	hat I attended the d			L-40	_, 19, to	10.6	58, 19	.,that I la	st saw t	he decease
alive on	10,5,58	. 19	, and that d	eath oc	curred of 10:	294 Fra	Me couses o	nd on the	dote	tated abou
	· ·		,				treet, city or town,		dule 3	DATE SIGN
ACTUAL	1) 1 7	1101	10 -1		40 7					DAIL SIGN
SIGNATURE	16: 11.10	10	ang/	M.D.	49 Fred	ierick	St. Tai	neyto	wn,	Md.
			1							10.7.
PHYSICIAN'S NAME (Type)	R.S. McVa	לסווב	n M.D.							20010
		-ABI								
220. BURIAL, CREMATIC REMOVAL (Specify	ON, 226. DATE THEREOF		22c. NAME OF CEMETE	ERY OR CR	EMATORY	22d. LOCA	TION (City, town, o	r county)	(	State)
Burial		158	Keysville	Come	tory	**			ha	
3. FUNERAL DIRECTOR		1	ADDRESS	ACMG			vsville,	TRAR'S SIGN		
Merch	vila ( ) Just	2				C'D BY REGIS				
C.O.Fus	s & Son, Tan	evto	own. Marvlar	h	DATE	OCT 9 '	30 Ch	Thung S. ?	haus,	

CERTIFICATE OF STATE Vane Miret Land the street of the Author in Continue Months Man Carrie Monarconte The transfer of the contract of the transfer of the contract o . De (Controllation de la controllation de la .C. Estatoa. R. A. Abrica | Dot. 11, 1958 | Fareviller Community | Court Bentify and Constitution of the Table

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I, PLACE OF DEATH				2. USUAL RESI	DENCE (Wh	ere deceased	lived. If Institution	on: Residenc	e before ad	mission)
a. COUNTY			MARYLAND	o. STATE	-land		b. COUNTY	Balti	more	Stan
Carroll	(If outside corporate limits,	write   c 15	NGTH OF STAY IN 16		TOWN	utside coroor	pte limits, write R			own) i.
RURAL and give		C. EC	NOTIFICITION OF STATE IN TO	e. citi ok		iornoa curpore	are mining, write K	OKAL GIIG 8	ive needed .	
Sykesvil	le		17 de	vs Bal	imore	3	- 2	VA	2.50	V
d. NAME OF HOSP OR INSTITUTION	ITAL (If not in hospitol, giv	re street oddret	s)	d. STREET					01	RESIDENCE N A FARM?
Springfi	eld State Ho	spital		1115 S. (	onkli	in Stre	et		YES	□ NO 🔀
NAME OF	First		Middle	to	đ	4. DATE	Mon	ith	Doy	Year
(Type or print)	Albert		John	Kuh	n	DEATH	Octobe	ar 17		19 58
. SEX		7. MAPPIED	NEVER MARRIED			19	AGE (In years		1 YEAR IF U	NDER 24 HRS.
							lost birthdoy)	Months	Doys Hou	urs Min.
Male	WILLIAM	WIDOWED [	DIVORCED [	Augus		1912	46 yrs.			
lo. USUAL OCCUPAT	ION (Give kind of work dorking life, even if retired)	one 10b. KIND	OF BUSINESS OR INC	OUSTRY 11. BIRTHP	ACE (Stote	or foreign co	untry)	12. CITI	IZEN OF WI	HAT COUNTRY
- Coming man ar ma	nking me, even ii temooj			Morr	vland			U.S	S.A.	
3. FATHER'S NAME				14. MOTHER'S		NAME				
Henry Ku					ces Sc	chroede				
S. WAS DECEASED EV	ER IN U. S. ARMED FORC		AL SECURITY NO. 17.	INFORMANT			Add	ress		
no	0		a	Springfi	eld St	tate He	ospital !	Record	ds	
	ATH [Enter only one cou	se per line for	(a) (b) and (c).)							LBETWEEN
	ATH WAS CAUSED BY:									ND DEATH
700	IMMEDIATE CAUSE (0)	Brone	chopneumon	la	300		CT C		day	8
1491X	DUE TO									
Conditions, if	any which )									
gove rise to	immediate (b)				-					
cause (a), stating										
lying couse last	· (c).									
PART II. O	THER SIGNIFICANT COND	ITIONS CONTI	RIBUTING TO DEATH B	UT NOT RELATED TO	) THE TERMI	INAL DISEASE	CONDITION GIV	EN IN PART	T 1(o) 19. W	REORMED?
CBS asso	e. with conv	nilgive	disorder,	mental de	eficie	ency wi	thout p	sychos		NO D
CBS asso  200. ACCIDENT V OR CONTRIBUTION (IF EITHER, NOTIF	VAS UNDERLYING []	20b. DESCRIBE	HOW INJURY OCCUR	RED. (Enter nature	of injury in	Post of or Pact	Holiton 181 a	0.000	anha 74	+4 =
OR CONTRIBUTIN	VAS UNDERLYING   13					rue co	abtragett	e ence	shugrr	CTD.
			l			Lane or				
20c. TIME OF INJU				PLACE OF INJURY factory, street, office			or lawn)	(C	County)	(Stote)
p. m.	19	While of work	I TOI WILLIE )							
			T1 20	19_5	0. 0	at aban	77 10 5	Ø.,		
21. I certify	that I attended the									
alive onQc	tober 17	_, 19_58_	, and that dec	th occurred at	9:00	A.M., fram	the causes of	and an th	he date st	
	7	1.01	2 /			ADDRESS (Str	eet, city or town,	stote)		DATE SIGNE
ACTUAL	austro 0	nel (	emp)	un Spr	ingfi	eld Sta	ate Hosp	ital	10/	17/58
SIGNATURE	1									
PHYSICIAN'S	//			C1-		7 - W-				
	Agustin del		M,DZ		SEATT	le, Ma				
220. BURIAL, CREMAT		220	NAME OF CEMETERY	OR CREMATORY		22d. LOCAT	ION (City, town,	or county)	(	Stote)
REMOVAL (Specif	" oct 20.1	958	Schwartz	Cemeter	Y	Balt	imoro,	Mary	land	
3. FUNERAL DIRECTO			ADDRESS			D BY REGISTI		STRAR'S SIC	SNATURE	
A -	Ioran 3000	E. E	altimore	St.		OCT 2 1			S. Krau	4
A OTTIL TE . IN	IOI all DOOR	) He	OT OTHER		DATE	AAL W.	00	- nummy	a. / wall	AL.

the funeral director. TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 by the hospital ar attending physician.

108: After this certificate has been signed by the attending physician and campletely filled in by the control of t er death. may be retained by the hospital ar attending physician.

TO FUNERAL DIFFOR: After this certificate has been signed by the attending physician page 3 shauld to detached far use as the burial-transit permit. Then please remove at the registrar prior to burial, cremation, ar remayal, and in any event within 72 hours of

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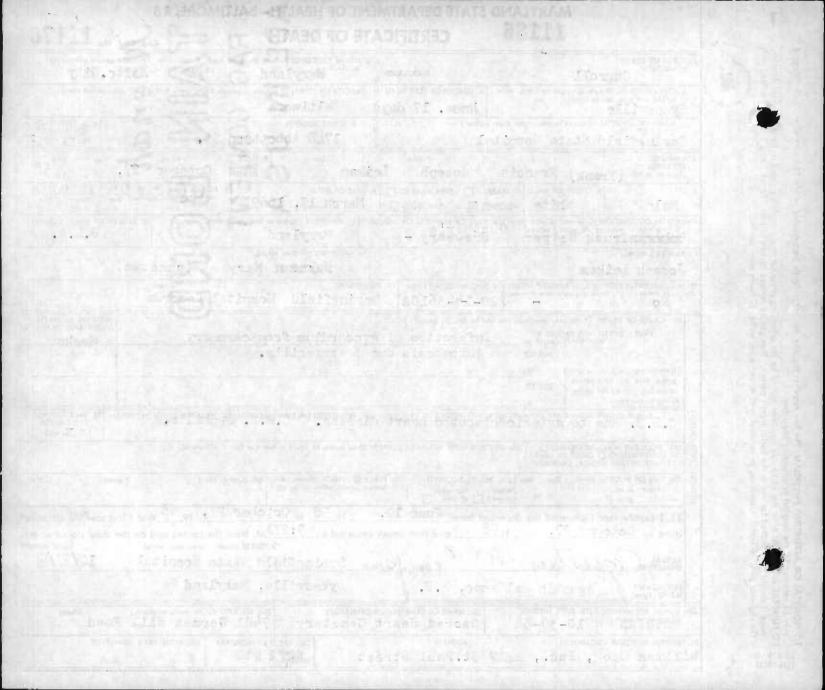
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11186

**CERTIFICATE OF DEATH** 

Reg. Dist. No. 11176

						Keg. Dist.		
1. PLACE OF DEATH o. COUNTY	rroll	MARYLAND	2. USUAL RESIDENCE (W	here deceased live	d. If institution b. COUNTY		o.City	
b. CITY OR TOWN (I RURAL and give no Sykesville	If outside corporate limits, write earest lawn)	LIMOS. 17 day	c. CITY OR TOWN (IF		imits, write RU	JRAL and give	nearest taw	m) 🗸
OR INSTITUTION	TAL (If not in hospital, give street  Ld State Hospital		d. STREET ADDRESS 1748 Abb	ottson S	t.		ON.	SIDENCE A FARM? NO
3. NAME OF DECEASED (Type or print) (F	rank) Francis	Joseph L	eikam Lost	4. DATE OF DEATH	Octobe		Day	Yeor 19 58
5. SEX Male	6. COLOR OR RACE 7. MARR		B. DATE OF BIRTH March 17, 1	.889 9. Ad	GE (In years st bighty) yrs.	Months Do		ER 24 HRS. Min.
during mast of work	ON (Give kind of work dane 10b. king life, even if refired) uck Helper	kind of Business OR INDU nther's Breweary -	USTRY 11. BIRTHPLACE (Stote Marylan	ar fareign country	)	12. CITIZE	U.S.	COUNTRY?
Joseph Lei	Lkam		14. MOTHER'S MAIDEN		(unk	nown)		
15. WAS DECEASED EVE (Yes, no. or unknown)	R IN U. S. ARMED FORCES? 16. (If yes, give wor or dates of service)		Springfield	Hospital	Recor			
PART I. DEA  420.  Conditions, if all gave rise to it couse (a), stating lying cause last.	ny, which (b) (b) DUE TO (c) (c)	Infarction of thrombosis du	e to arteriti	Ls.		(	Meel	D DEATH
3 0 26	HER SIGNIFICANT CONDITIONS OF THE CONTROL OF THE CO					EN IN PART 1(		AUTOPSY DRMED?
O HE ETHER, NOTIFY	MEDICAL EXAMINER)	CRIBE HOW INJURY OCCURRI	LACE OF INJURY (Hame, farm			(Cour	ntu)	(State)
Hour a.m. p.m.	19 While at wor	k at work	ictary, street, affice bldg., etc	c.)			724	
21. I certify the alive an Oct.  ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type)	ober 27, 195  Agustin delCa	ond that death	n accurred at 9:27  Springfie  Sykesvill	ADDRESS (Street, eld State	city or town, s	nd an the	date stat	deceased ed above ATE SIGNED 27/58
22a. BURIAL, CREMATIO REMOVEL (Specify)		22c. NAME OF CEMETERY C Sacred Hear		22d. LOCATION 7401 Be			oad (Sto	le)
23. FUNERAL DIRECTOR'S	s signature ok, Inc., 1217	ADDRESS St.Paul Str	2014	D BY REGISTRAR 2 9 58		TRAR'S SIGNA		



> VS A15 (4) 15M 9/5S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 9 FilmG235 10-21-58 et CERTIFICATE OF DEATH Reg. Dist. No. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. COUNTY b. COUNTY Baltimore City MARYLAND Carroll Maryland b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give negrest town) 22yr.lmo.2days Sykesville Beltimore City d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION d. STREET ADDRESS e. IS RESIDENCE ON A FARM? Springfield State Hospital YES NO T NAME OF First Middle 4. DATE Lost Month Year DECEASED OF DEATH 19 58 (Type or print) Luigi Lieto October 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. B. DATE OF BIRTH 9. AGE (In years lost birthday) Doys Months Hours DIVORCED T WIDOWED | White August 62° USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Stote or foreign country) 12. CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) Italy 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Unknown Unknown 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address Springfield Hospital Records no 18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o). Hepatoma vears 155.0 DUE TO Conditions, if ony, which gove rise to immediate **DUE TO** cause (a), stating the underlying couse tost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? Schizophrenic reaction, paranoid type.

CCIDENT WAS UNDERLYING | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.) YES NO TO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY 20e. PLACE OF INJURY (Home, farm, 20f. (City or town) 20d. INJURY OCCURRED Doy, Year (County) (Stole) foctory, street, office bldg., etc.) Hour o. m. Not while at work at work 21. I certify that I attended the deceased from March 7 1955, to October 7 1958, that I last saw the deceased alive on October 7 , and that death occurred at 4:45p M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL Springfield State Hospital. Sykesville. PHYSICIAN'S NAME (Type) Agustin delCampo Maryland, 10/7/58 220. BURIAL CREMATION. 22c. NAME OF CEMETERY OR GREMATORY 22d. LOCATION (City, town, or county) (Stote) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE XDDRESS 24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE OCT 1 4 '58 arthur & Traves

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	1 PLACE OF DEATH	

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11188 CERTIFICATE OF DEATH

Reg. Dist. No. 11178

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1, 1	PLACE OF DEATH	croll		MARYL	AND	2. USUAL RESID o. STATE Maj	ence (When	d deceased	tived. If institution b. COUNTA	arro.		dmissio	on)
-		f outside carporate limi	ts, write	c. LENGTH OF STAY II	N 1b	c. CITY OR TO	OWN (If our	tside carpor	ote limits, write R	URAL ond g	ive nearest	town)	
		Westmins	ter	6mo		X Rural	LWe	stmi	nster				
	d. NAME OF HOSPIT OR INSTITUTION	AL (If not in hospitol, g	ive street o	oddress)		d. STREET AL		# 6			e. 1	S RESID	DENCE FARM? NO
	NAME OF DECEASED (Type or print)	MARIE	st	VIRGIO	) i A	MA	STIN	4. DATE OF DEATH	(De)		Day 6		ear
5. 5	SEX	6. COLOR OR RACE	7. MARR	IED NEVER MARRIE		8. DATE OF BIRTH			9. AGE (In years last buthday)	IF UNDER Manths			
Í	emale	white	WIDOWE	DIVORCED		4-11-1	1893		65 yrs.	Munins	Doys H	aurs	Min.
10a	during most of work housewi	king life, even if retired	dane 10b.	KIND OF BUSINESS OF	INDU		yland		untry)		S.	VHAT (	COUNTRY?
13.	FATHER'S NAME					14. MOTHER'S							
		Elgouis	Dos	ter		Ann:	ie r	. Gi	llard				
15.	WAS DECEASED EVE	R IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURITY NO.	17. II	NFORMANT			Add	ress			
(70:	no, or unknown)	(If yes, give war or dates of s	ervice)		M	cs. Artl	nur C	.Shi	pley, Sr	. S	ame		200
-	Conditions, if a gove rise to i couse (a), stoting lying cause last.	the under-	)										
CERTIFICATION	PART II. OTI	HER SIGNIFICANT CON	IDITIONS C	CONTRIBUTING TO DEA	IH BUI	NOT RELATED TO	THE TERMIN	IAL DISEASE	CONDITION GIV	EN IN PAKI		PERFOR	NO D
	20a. ACCIDENT W/OR CONTRIBUTING	AS UNDERLYING  CAUSE OF DEATH MEDICAL EXAMINER)	20b. DES	CRIBE HOW INJURY OF	CURRE	D. (Enter nature at	injury in Po	art 1 or Part	II of item 18.)				
MEDICAL	20c. TIME OF INJUS Haur o. m. p. m.	RY Month, Doy, Ye	ar 20d. If While of war	Nat while	20e. PL fa	ACE OF INJURY () ctary, street, affice	lame, farm, bldg., etc.)	20f. (City	or town)	(C	ounty)		(State)
20.	ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	aucs J.	- 19: - 71	MARSH	death	accurred at.	44 05 E We	EST	the causes of reel, city ar town, IAIN	state) S#		stated DA	d abave. TE SIGNED TO S
120	REMOVAL (Specify)			Harmony		r CREMATORY		Carr	Oll Co	Md.		(Stote	)
23.	FUNERAL DIRECTOR			ADDRESS nfield, Mo	đ.		240. REC'D	BY REGIST		STRAR'S SIC	11		

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Reg. Dist. No.

								Keg. Di	ST. 140.	
o. COUNTY	rell		MARY	- 11	o. STATE Mary	where deceased	l lived. If instituti b. COUNTY			odmission)
b. CITY OR TOWN (I RURAL and give no	If outside carporate limi earest town)	its, write	c. LENGTH OF STAY		c. CITY OR TOWN (IF			0.4	,	
Sykesvill	8,		1m 12 da	ys	Baltimor	e 14, Ma	l,	3 V a		
OR INSTITUTION	TAL (If not in hospital, g	give street o	oddress)		d. STREET ADDRESS					IS RESIDENCE ON A FARM?
Springfie	ld State H	ospit	al		4701 Cata	1pha Ro	oad		Y	ES NO NO
3. NAME OF DECEASED (Type or print)	Iaura	rst	L. Middle	M	Lshenko	4. DATE OF DEATH	Mor 10	nth	Day	Yeor 19 58
s. SEX		7. MARR	IED T NEVER MARRI		ATE OF BIRTH	total =	9. AGE (In years	Page 1 and 1	TYEAR IF	UNDER 24 HRS
Fam	White	WIDOWE		- 17	9-12-07		lost birthdoy) 51 yrs.	Months	Days H	lours Min.
00. USUAL OCCUPATIO	ON (Give kind of work	done 10b.			11. BIRTHPLACE (Stote	e or foreign co		12. CI	TIZEN OF	WHAT COUNTRY
during most of wor	king life, even if retired 15 <b>ewi fe</b>	1)			Penns	ylvania			U.S.	
3. FATHER'S NAME				1	4 MOTHER'S MAIDEN	NAME				
Horme	Leibold				Alice Ray	hold				
S. WAS DECEASED EVE	R IN U. S. ARMED FOR	RCES? 16.	SOCIAL SECURITY NO	. 17. INFO			Add	Iress		
[Yes, no or unknown]	If yes, give war or dates of s	100				2 P				
ne	The fact of		unkn		S.S.Hospita	T TABGE	THE S		las menu	
The second secon	ATH [Enter only one co ATH WAS CAUSED BY: IMMEDIATE CAUSE (o		riolar net		leresis				ONSET	AND DEATH
Conditions, if a										
couse (a), stating lying couse lost.		c)								
C.B.S.ass	HER SIGNIEICANT CON	re bra	ONTRIBUTING TO DE	clero	RELATED TO THE TERM	MINAL DISEASE Sychotic	c reacti	VEN IN PAR	T 1(o) 19.	WAS AUTOPSY PERPORMED? ES NO
C.B.S. ASS	AS UNDERLYING CONTROL CAUSE OF DEATH MEDICAL EXAMINER)	20b. DESC	CRIBE HOW INJURY O	CCURRED. (I	Enter noture of injury in	Part I or Part	II of item 18.)			
20c. TIME OF INJUR Hour o. m. p. m.	RY Month, Doy, Ye	While	Not while	20e. PLACE factory	OF INJURY (Home, far r, street, affice bldg., et	rm, 20f. (City	or town)	(1	County)	(Stote)
21. I certify the olive on 10-	4	decease		death o	curred o <b>6:20</b> Springfie	A_M, from	the causes of	and on t		
PHYSICIAN'S	dmind Lust	haus	M.D.	M.D	Sykesvill					
220 BURIAL, CREMATIC REMOVAL (Specify)	ON, 22b. DATE THEREC	OF 5	22c. NAME OF CEM	ETERY OR C			City, towns		7	(State)
23. FUNERAL DIRECTOR	100	10	ADDRESS	May a	00 10111	1	- juice	0	//	4

funeral director, TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIPPLIOR: After this certificate has been signed by the attending physician and campletely filled in by the page 3 should adelached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 the registrar prior to burial, cremation, ar removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/SS

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ath. After this copy of this

#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

### 11190 CERTIFICATE OF DEATH

11180

Reg. Dist. No.....

	1. PLACE OF DEATH	2. USUAL RESIDENCE (HOME) OF DECEASED	
	COUNTY Carroll MARYLAND	STATE Maryland COUNTY Carr	011
2	CITY (If outside corporate limits, write RURAL OR end give neerest town) TOWN Taneytown	CITY (If outside corporeta limits, write RURAL and give near OR TOWN Taneytown	rest town)
1	HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET (If rural give location) ADDRESS 15 York Street	
	3. NAME OF (First) (Middle)  DECEASED (Type or Print) William C. N. Mye	(Lest) 4. DATE (Month) OF DEATH October	(Day) (Year) 26, 19 58
	5. SEX 6. COLOR OR RACE 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed March	F BIRTH 9. AGE lest birthdey IF UNDER Months Months	1 YEAR   IF UNDER 24 HRS. Days   Hours   Min.
	10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Labor  10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Labor  10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Labor  10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Labor  10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if refired) Labor		COUNTRY?
Е	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	
	Jerome Myers	Sarah Jane Koontz	
	15. WAS DECEASED EVER IN U. S. ARMED FORCES?   16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS	
H	(Yas, no, or unk.) (If Yes, give wer or detes of service)	Mr. Lloyd Myers, Taneytown	, Md.
	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	TIFICATION	INTERVAL BETWEEN ONSET AND DEATH
	immediate cause (a) myo candit	is Chronic	6 mo
	ANTECEDENT CAUSE(S)  DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.  (C)	l'arteriorscleursis	zyrs.
	TO THE SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OF CONDITION CAUSING DEATH.  Cauche Jan	u (Lissue)	lyear
0	196. DATE OF OPERATION 196. MAJOR FINDINGS OF OPERATION	<b>6年1月日本日本日本日本日本</b>	YES NO
	OR CONTRIBUTING CAUSE OF DEATH OF INJURY street, office bidg., etc.)  (IF EITHER, NOTIFY MEDICAL EXAMINER)	ic. WHERE DID INJURY OCCUR? (City or town) (Coun	(State)
	21d, TIME OF INJURY (Month) (Dey) (Yeer) (Hour) 21e, INJURY OCCURRED While Not while et work et work	211, HOW DID INJURY OCCUR?	
	22. I hereby certify that I attended the deceased from June 1.	, 19 57, to 10/26 , 19 58, that I	last saw the deceased
1	alive on Oct. 17, 1958, and that death occurred at.	11: 30 PM, from the causes and on the date states	
10M	SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
	C. CCCCCCC C.	aneylown hid	10/27/57
A15C 1-55	23. BURIAL, CREMATION, DATE THEREOF NAME OF CEMETERY OR REMOVAL (SPECIFY)	CREMATORY LOCATION (City, town, or county)	(State)
		d Cemetery Taneytown, Mar	. 44
1	24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE OCT 2 8 '58 Trank		ADDRESS
	DATE OF A COMME	C. O. Fusa & Son Tenevitown	larvland

MATHY AND STATE DEPARTMENT OF BEALTH. BALTHOLD, 18

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funeral director, yld be filed with

may be retained by the haspital or attending physician.

2 FUNERAL DY TOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should by detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 the registrar prior to burial, crematian, or removal, and in any event within 72 fours offer death. TO FUNERAL DIVER

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 VS A15 (4) 15M 9/55

	11.	131	CERTITION	TIE OI DEATI			Reg. Dist.	. No.	
1. PLACE OF DEATH a. COUNTY	Carroll		MARYLAND	2. USUAL RESIDENCE (WI o. STATE Mar	here deceased <b>yland</b>	lived. If institution b. COUNTY	nı Residence Balt		ssion)
Sykesville	f autside carporate limi parest lawn)		tmos . 20day	c. CITY OR TOWN (IF a	more 3.	•	JRAL and giv	ve nearest tav	wn)
A NAME OF HOSPIT	AL (If not in hospital, gld State Ho	ospital		d. STREET ADDRESS	Old Ha	rford Rd		ON	A FARM?
3. NAME OF DECEASED (Type or print)	Ahh	Amanda	Middle Gardiner	Old	4. DATE OF DEATH	October	8,	Day	Year 19 58
5. SEX Female	6. COLOR OR RACE White	WIDOWED T	ON THE SECOND OF	November 14		9. AGE (In years last birthday) yrs.	The state of the s	YEAR IF UND	The second second second
10a. USUAL OCCUPATION during mast of work Housewife	ting life, even if retired	dane 10b. KIND OF	BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stote Maryland	ar fareign ca	untry)		S.A.	T COUNTRY?
13. FATHER'S NAME	George I	. Gardine	er	14. MOTHER'S MAIDEN P	NAME				
15. WAS DECEASEDEVER	R IN U. S. ARMED FOR (If yes, give wor or dates of s			NFORMANT pringfield Ho	spital	Records	ess		
PART I. DEA' 491X Canditians, if ar		Bronch	, (b), and (c).]	a				ONSET AND DAY	D DEATH
gave rise to in cause (a), stating (lying cause last.	The under- DUE TO	)	TING 19 DEATH BUT	POUR NE STEEL TO THE LEVE	INAL DISEASE	COMBILION CIN	HIN PART	1(a) 19. WAS	AUTOPSY
brain dis	sease with	psychotic	c reaction	Fracture nec	k of f	emur, rigi	ht.	YES	NO E
Y 20c. TIME OF INJURY Haur a. m. p. m.	Y Manih, Day, Yei		while for	ACE OF INJURY (Hame, form ctary, street, office bldg., etc	n, 20f. (City	ar tawn)	(Ca	unty)	(State)
		deceased from 19 58	and that death		P.M. fram ADDRESS (SIR eld St	the causes a eet, city or town, a te Hosp:	nd an the	date state	ted abave
220. BURIAL, CREMATION REMOVAL (Specify) BURIAL	10/11/5	8 AM	AME OF CEMETERY O		22d. LOCAT	ION (City, town, a	r county)	(Sic	ate)
23. FUNERAL DIRECTORY	S NGNATURE	5 U /	DRESS	7/1 7/1 140. REC'	D BY REGISTI		TRAR'S SIGN	11	

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

. IS RESIDENCE

Hours

INTERVAL BETWEEN

PERFORMED? YES NO

(Stote)

(State)

Day

U.S.A.

(County)

26

ON A FARM?

YES NO

Year

10 58

15M 9/55

funeral director,

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	777	20	CEKTIFICA	AIE OF D	EAIH			Reg. Dis	t. No.	
o. COUNTY	arroll		MARYLAND	2. USUAL RESID o. STATE	Maryl		lived. If institution b. COUNTY			odmission)
b. CITY OR TOWN RURAL ond give Sykesvi.	(If outside corporate limits nearest town)		mos.14da	rs	Gaith	tside corpore ersbur	te limits, write R	URAL end 9	2	V
OR INSTITUTION	PITAL (If not in hospitol, given the late of the late			d. STREET AC	Route	#1				IS RESIDENCE ON A FARM? YES NO
NAME OF DECEASED (Type or print)	First Nett:		Middle nce Duva	losi 11 PURD		4. DATE OF DEATH	Mon Octobe	r	Day	Yeor 19 <b>58</b>
Female	6. COLOR OR RACE	7. MARRIED NI	DIVORCED [	B. DATE OF BIRTH			last birthday) 65 yrs.	Months	Doys	Hours Min.
Housewi:	TION (Give kind of work di orking life, even if retired) Ce	one 10b. KIND OF	BUSINESS OR INDU	Mary	land		untry)		S.A.	WHAT COUNTR
	ah T. Duvall				an Wa					
Yes, no. or unknown)	VER IN U. S. ARMED FORC	vice)	3-6502-D	NFORMANT Spring	field	Hespi	ital Rec			
the state of the s	ony, which (b), immediate g the under-		sclerotic	heart di	sease				ONSE.	VAL BETWEEN T AND DEATH DATS
C.B.S.a	THER SIGNIFICANT COND BSOC. WITH CET WAS UNDERLYING  NG CAUSE OF DEATH	rebral ar		rosis wit	h psy	chotic	reacti		-	WAS AUTOPSY PERFORMED? YES NO
(IF EITHER, NOTI 20c. TIME OF INJ Hour o. n p. n	FY MEDICAL EXAMINER) URY Month, Doy, Yea		while fo	ACE OF INJURY (H ctory, street, office			or town)	(0	(ounty)	(State
21. I certify alive an O	that I attended the ctober 5.	19.58	and that death	M.D. Sprin	4130A	M, fram ADDRESS (Str.	the couses o	and on th		
	ION, 226. DATE THEREO	22c. NA	ME OF CEMETERY C			22d. LOCATI	ON (City. town, dfield	or county)		(Stote) Md.
23. FUNERAL DIRECTO			tonsvill	- 37.0	240. REC'D	BY REGISTR		strar's sic		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

TO FUNERAL DIP TOR: After this certificate has been signed by the attending physician and completely filled in by page 3 shauld. Hetached far use as the burial-transit permit. Then please remave carbon papers. Pages 1 and 21 the registrar prior to burial, cremation, ar remaval, and in any event within 72 haurs after death. VS A15 (4) 15M 9/SS

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11184

Rea. Dist. No. 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) PLACE OF DEATH a. COUNTY Carroll Balto.City MARYLAND Maryl and b. CITY OR TOWN (II outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville Byrs 10mos 20days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS 1538 Stonewood Rd. Springfield State Hospital YES NO DO NAME OF DATE Middle DECEASED 29. 58 May Belle Lantz Reeve October (Type or print) DEATH 19 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 18. DATE OF BIRTH 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS. Months April 11, 1872 86 Female White WIDOWED DE DIVORCED T 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? Maryland U.S.A. Housewife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Henry Lantz Elizabeth Lantz 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. No Springfield Hospital Records. INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: Bronchopneumonia Davs IMMEDIATE CAUSE (o) DUF TO Conditions, If ony, which gave rise to immediate couse DUE TO (a), stating the underlying couse fost. B.S. assoc with dist of metabolism growth or nutrition with senile brain performed? disease with psychotic reaction. Fracture, comminuted, right femur. 200. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port 1 or Part 11 of Item 18.) Pushed to floor by another patient. Month, Doy, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, form, 1 20f. (City or town) 20c. TIME OF INJURY (County) (State) While Not while of work Sykesville Carroll Md. 21. I certify that I took charge of the remains described above, held on Autopsy . Inspection . Inquiry 3 opinian deoth resulted fram: Natural causes , Accident , Suicide , Homicide , Undetermined monner DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER 10/30/58 **EXAMINER'S** James T. Marsh, M.D. DEPUTY MEDICAL EXAMINER NAME (Typé) 220. BURIAL, CREMATION, 1226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, lown, or county) REMOVAL (Specify) 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE

DATE

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	111	195	CERTIFI	CAI	E OF DEATH	4		Reg. Dis	. 11	185
1. PLACE OF DEATH o. COUNTY Carr	roll		MARYLA		. USUAL RESIDENCE (WI	nere deceose	d lived. If institution b. COUNTY	on: Residenc	e before od	Imission 281 Contry
b. CITY OR TOWN RURAL ond give Sykes ville			c. LENGTH OF STAY IN ne year 19da:		c. CITY OR TOWN (IF a	outside corpo		URAL and g		town)
d. NAME OF HOSE	PITAL (If not in hospital, gled State Ho	ive street or	dress)	ys	d. STREET ADDRESS 225 Winter	Stree		/ 0 0	e. IS	RESIDENCE IN A FARM?
3. NAME OF DECEASED (Type or print)	Alvia		Middle		Reichard	4. DATE OF DEATH	Oct, 14	***	25°2	Yeor 19 58
5. SEX Male	6. COLOR OR RACE White	7. MARRIE	DEVER MARRIED		10-4- 80		9. AGE (In years lost birthdoy) 78 yrs.	-	YEAR IF U	NDER 24 HRS. urs Min.
during most of w	TION (Give kind of work prking life, even if retired	one 10b. K	C. PLANT	_	Germany		country)	U.S.		HAT COUNTRY
13. FATHER'S NAME	Theodore	Reich	oyet ard		Unknown	NAME				
	VER IN U. S. ARMED FOR	CES? 16. SC			ormant	ds.	Add	ress		
18. CAUSE OF D	EATH (Enter only one co EATH WAS CAUSED BY: IMMEDIATE CAUSE (d			s: He	art Disease				INTERVA ONSET A	L BETWEEN ND DEATH
Canditions, if gove rise to cause (a), stalin lying couse los	g the under-	Gene	ralized Art	eric	sclerosis	71 6			years	3
20a. ACCIDENT V	THER SIGNIFICANT CON  TELL SYNCY  COS WILD DE  VAS UNDERLYING   IG CAUSE OF DEATH  EY MEDICAL EXAMINER)	venot	ic reaction	S.	TRELATED TO THE TERMINITE OF THE TERMINI			en in part latory	1(o) 19. W PE YES	AS AUTOPSY REFORMED?
20c. TIME OF INJU	10	While	Not while of work	e. PLACE foctor	OF INJURY IHome, form y, street, office bldg., etc	20f. (Cit	y or town)	(Ce	ounty)	(Stote)
olive on_1	that I attended the				coursed of 9,35. Springfiel	ADDRESS (S	m the couses of	and on th		he deceosed tated above DATE SIGNEE 11-26-5
PHYSICIAN'S NAME (Type)  220. BURIAL, CREMATI REMOVAL (Specif	2 10/18		22c. NAME OF CEMETER ADDRESS	RY OR C	Cem.		TION (City, town,	or county) STRAR'S SIG	- 1	State)
23. FUNERAL DIRECTO	Prince	Ha	ADDRESS /	- -	Zele DATOCT	1		STRAR'S SIG		

MARYLAND STATE DEPARTMENT OF HEALTH-RALTIMORE 18

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#### MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11196 **CERTIFICATE OF DEATH** 

11186 Reg. Dist. No.

1. PLACE OF DEA o. COUNTY Ca.1	rroll		MARYLA		USUAL RESIDENCE (No. STATE Mary		d lived. If instituti b. COUNTY		ce before ad	Section 1
b. CITY OR TO	WN (If autside corporate limi	ts, write c.	LENGTH OF STAY IN	1 1b	c. CITY OR TOWN (I	f autside carpo	orate limits, write F	RURAL ond g	give nearest	town)
	sville	]	m 14 days	3	Baltimor	e (22) 1	Md.	035	3.2	
d. NAME OF H	OSPITAL (If not in haspital, g	ive street add	ress)		d. STREET ADDRESS				e. IS	RESIDENCE N A FARM?
	gfield State H	Hospita	1		6743 Woo		1			NO NO
3. NAME OF DECEASED	Fir	rst	Middle		Lost	4. DATE	Mor		Day	Yeor
(Type ar print)	Leonal		Smith		ichardson	OF DEATH	10		19	1958
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	B. D.	ATE OF BIRTH		9. AGE (In years last birthday)	Manths Manths		NDER 24 HRS.
M	W	WIDOWED [	DIVORCED		8 - 21 -7	1	87 yrs.	Manins	Days Ho	urs Min.
100. USUAL OCCL	JPATION (Give kind of work of working life, even if retired	done 10b. KIN	D OF BUSINESS OR	INDUSTRY	11. BIRTHPLACE (Sto	te or fareign c	ountry)	12. CIT	IZEN OF W	HAT COUNTRY?
	ill worker	576	ELMEG	12	Ohio			U	I.S.A.	
13. FATHER'S NAM				14	. MOTHER'S MAIDEN	NAME				
T	ames Richards	010			Halan	Everso	n			
15. WAS DECEASE	DEVER IN U. S. ARMED FOR		CIAL SECURITY NO.	17. INFO		DAGISO	Add	lress		
(Yes no, or unknown)	(If yes, give wor or dates of s		NONE	Consta		TARA TE		On a and		
no no	r ocama fr		<del>unk</del> n	Spr	ingfield S	22 2 2 3 1	ospical i	racord		L BETWEEN
	OF DEATH [Enter only one co I. DEATH WAS CAUSED BY:								ONSET A	ND DEATH
	IMMEDIATE CAUSE (o	Art	erioscler	otic	cardiovasc	ular d	isease		year	rs
42	DUE TO	)								
	, if any, which ) (b	)								
	to immediate DUE TO	)								
lying cause		:)								
C.B.	I. OTHER SIGNIFICANT CON S. assoc. wit	cere	oral arter	H BUT NOT	RELATED TO THE TER	h seni	Lity	VEN IN PAR	PE	AS AUTOPSY ERFORMED?
20a. ACCIDEN OR CONTRIBI	NT WAS UNDERLYING [] UTING [] CAUSE OF DEATH OTIFY MEDICAL EXAMINER)	20b. DESCRI	BE HOW INJURY OCC	URRED. (E	nter nature af injury i	n Part I ar Par	t 11 of item 18.)			
Hour	INJURY Manth, Day, Ye a.m. p. m.	While _	RY OCCURRED 20 Nat while at wark		OF INJURY (Hame, fa street, affice bldg., e		y ar tawn)	(0	Caunty)	(State)
21. 1 certi	fy that I attended the	deceased	from 9	- 5 -	_, 19_58, to	10 -	19- 19 58	3., that I	last saw t	he deceased
alive an	10 - 18 -		, and that d							
diffe dil	0		, dila illai a	icam ac	corred of Mariana		itreet, city ar town,		ne date s	DATE SIGNED
ACTUAL SIGNATURE_	Edmund =	Tust	hou	M.D.	Springfi					10-19-58
PHYSICIAN'S NAME (Type)	Edmund Lus	thaus )	A.D.		Sykesyil	le. Ma	ryland	*		
22a BURIAL, CREA		OF 2	2c. NAME OF CEMETI	ERY OR-CR			TION (City, tawn,	ar county)		(Ștate)
REMOVAL (SI	10/23/3	18	VNION	/		STUI	BINVILL	-E -	- On	10
23. FUNERAL DIRE	CTOR'S SIGNATURE	elley,	ADDRESS	the, he	24a. RE	C'D BY REGIS		ISTRAR'S SIG		
					1 - 1 - 1					

TILLY CERTIFICATE OF DEATH 6-Strang to the free news bears at some in the in-concerned search from the state of the state Marting the array and a sufficient of the control o 

VS A15 (4) 15M 9/SS

MARYLAND	STATE DEPARTMENT	OF HEAL	TH-BALTIMORE,	18
11197	CERTIFICATE	OF DEA	TH	

Reg. Dist. No. 11187

	CE OF DEATH					2. USUAL RES	IDENCE (Wh	ere deceased	lived. If instituti	anı Resider	ce before	odmissi	nn)
a. (	Cari	2077			MARYLAND	o. STATE	arvlan		b. COUNTY		Ltimo	11/4	71
b. (	CITY OR TOWN (IF	outside carporate lim	ts, write	c. LENGTH OF	STAY IN 16		The second second		ote limits, write R			0. 0.	
1	RURAL and give new	irest town)		y. 10	m 3 6		ltimor				1		
d.	NAME OF HOSPITA	L (If not in haspital, s			A14 3 0	d. STREET		9 1071		V0/	- April -	IS RESI	DENCE
	OR INSTITUTION	eld State	Ineni	†.al		1,70	00 Har	ford B	oad			ONA	
3 NA	ME OF	Fi			Aiddle	to		4. DATE		4			
DE	CEASED pe or print)	Ann			rgaret	Robins		OF DEATH	Octo	ber	Doy 7		58
5. SEX		6. COLOR OR RACE				8. DATE OF BIRT			P. AGE (In years	IF UNDER	1 YEAR II		
F	emale	White	WIDOWI		ORCED	Februar		1873	last birthdoy)	Months		Hours	Min.
10o. U	SUAL OCCUPATIO	V (Give kind of work	dane 10b.		See al		V			12. CI	IZEN OF	WHAT	COUNTRY
d	uring most at worki	ng tife, even if retired	)				~				7 1	/	7.
13. FA	HOUSEWI!	.೮				14. MOTHER	Jerman	<b>-</b>			CAN STREET	WIIC	
	Tinles	nown						nown					
15. W		IN U. S. ARMED FOR	CES? 16.	SOCIAL SECURIT	Y NO. 17. I	NFORMANT	OIM	110 W11	Add	(033	•		
(Yes, no	(Inknown)	yes, give wor or dates of s	ervice]	1001		nni nafi	+2 h [a	ata Ho	spital H	Pacana	3		
110	CAUSE OF DEAT	H [Enter only one co	use per li	no for (a) (b) or		NA TIBLE	510 D0	a. 00 110	Spr oar i	(GCO) (		VAL BET	PAVEEN
"	PART I. DEAT	H WAS CAUSED BY:	126	20116	LAPA	VEIIN	10N	14	0		ONSE	AND	DEATH
	111111	IMMEDIATE CAUSE (d	1000	h	- 1-0	- 0	1		<del>/                                    </del>		CEE	-	70
	416X		a	pere	arco	1.00	0						
	Conditions, if an		)	/	. 0	1	-	. /	4 '54				
	cause (a), stating t ying couse last.	ne under-	al	UMI	A KI	Ruma	to 1	Jean	+ Drie	ase	6	IRC	211
Z		R SIGNIFICANT CON	DITIONS (	ONTRIBUTING T	O DEATH BUT	NOT RELATED TO	0/	,	7 4 0 0		1	WAS A	UTOPSY
N A	Chron	ic brain s arterioscI	yndrç	me asso	ciated	with ci	rculat	ory di	sturban	ce, w	ith ,	PERFOR	
20	a. ACCIDENT WAS	UNDERLYING []	20b. DES	CRIBE HOW INJU	DS VCITC	D. (Enter nature	of injury in P	art I or Part	II of item 1B.)			ra fill	40 LJ
CERTIF OC S	R CONTRIBUTING	UNDERLYING A CAUSE OF DEATH											
		Manth, Day, Ye	or 20d. II	NJURY OCCURRE	D 20e. PL	ACE OF INJURY	(Hame, farm,	20f. (City	ar tawn)	- 11	County)		(State)
MEDICAL	Haur a.m.	19	While	Not while	fo	ctary, street, affic	e bldg., etc.	)		,	200177		(5.5.6)
-	p. m.			tend t		- 120	2 ^-	1 - 2	n'C	)			
2	I. I certify the	at I attended the	deceas										
a	live on Oct	ober 1	, 125	o, and	that death	occurred at			the causes		he date		d abave
A	CTUAL GNATURE	Viler S.	De.	alm		Conn			eet, city ar tawn,	100		7.0	1 /7 / CS
	GNATURE		-			м.D. <u>Spi</u>	diusini	ela St	ate Host	oltal			1.11.50
SP				T 3.5		C-3	ro card 3	le. Ma	mrland				
PI	HYSICIAN'S AME (Type)	lita S. Gl	alın,	M. D.		DY	769ATT	400	TATCHE				
220. B	AME (Type)	tita S. Gl:			CEMETERYO	R CREMATORY			ON (City howe)	or county)	d	(State	·)

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VS A15 (4)

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 11198 CERTIFICATE OF DEATH

11189

Reg. Dist. No. 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. COUNTY b. COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 16 c. CITY OR TOWN (M autside carporate limits, write RURAL and give nearest town) RURAL and give pearest town) d. NAME OF HOSPITAL (If not in haspital, give street address) d. STREET ADDRESS OR INSTITUTION ON A FARM? NAME OF Middle 4. DATE Last Manth Day Year DECEASED DEATH 1958 (Type or print) S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Months Days Hours WIDOWED 14 DIVORCED USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY? during-most of warking life, even if retired) 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 17. INFORMANT 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. Address 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSEL AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracer **DUE TO** Canditians, if any, which gave rise to immediate DUE TO catse (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED? YES NO NO 200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY 20e. PLACE OF INJURY (Hame, form, 20f. (City or town) Day, Year 20d. INJURY OCCURRED (County) (State) factory, street, affice bldg., etc.) Haur a. m. While Not while at work at work 21. I certify that I attended the deceased from 1920, that I last saw the deceased and that death occurred aloga _M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE TXC PHYSICIAN'S NAME (Type) 6 22c. NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION, 22b. DATE THEREOF. 22d. LOCATION (City, tawn, or county) (State) REMOVAL (Specify) FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Orthung S. Traces

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DEPARTMENT OF HEALTH—BALTIMORE, 18

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VS A15 (4) 15M 10/57

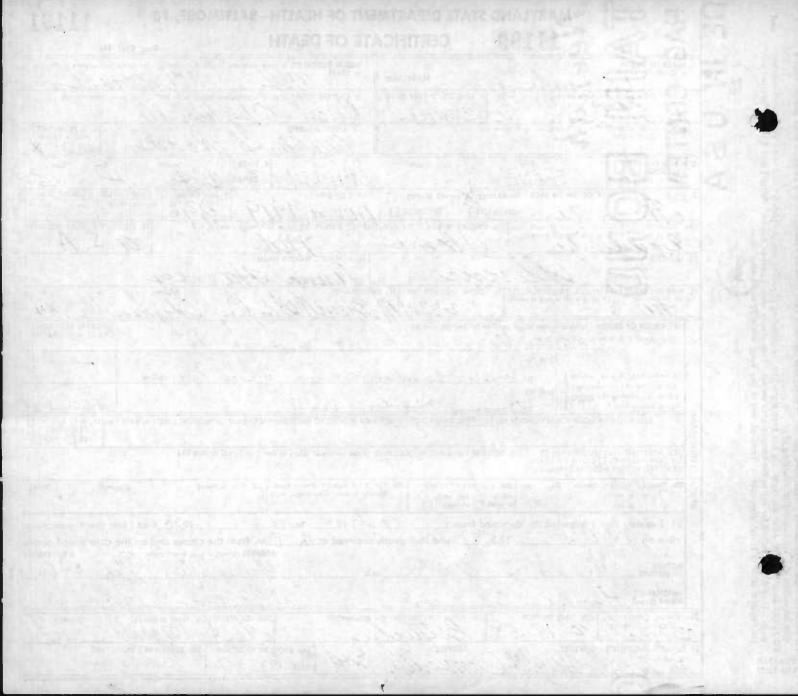
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ARYLAND	STATE DEPARTMENT	OF	HEALTH-BALTIMORE,	18
11199	CERTIFICATE	OF	DEATH	

M

11191 Reg. Dist. No.

					-	
1. PLACE OF DEATH o. COUNTY	malle	MARYLAN	II a STATE	Where deceased lived. If in b. CO		before admission)
AMAN -	Sintersitell	3 years	c. CITY OR TOWN	If autside corporate limits, w	rrite RURAL and give	nearest fown)
d: NAME OF HOSPI OR INSTITUTION	TAL (If not in hospital, give stree	t address)	d. STREET ADDRESS	and Ro	ad	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	SADE	Middle	SHIPLEY	4. DATE OF DEATH OS	Month 14	Day Year 1958
5. SEX	6. COLOR OR RACE 7. MAI	VED DIVORCED	100.4.1	919 Plast birth	years IF UNDER 1YI doy) Months Do	EAR IF UNDER 24 HRS. bys Hours Min.
during most at war	ON (Give kind of work done 10krking life, even if retired)	KIND OF BUSINESS OR IN	- m	Ul	12. CITIZE	S. A.
13. FATHER'S NAME	Aller	ener	14. MOTHER'S MAIDE	Harr	ey	
15. WAS DECEASED EV	ER IN U. S. ARMED FORCES?	1. SOCIAL SECURITY NO. 11.	MACHOWELLE	thifling 6	Hadelow	ille, red.
	ATH [Enter only one couse per ATH WAS CAUSED 8Y: IMMEDIATE CAUSE (a)	line for (o), (b), and (c).]	want, me	Rastalie to		INTERVAL BETWEEN ONSET AND DEATH
Canditians, if		in, lumb	a vertilie,	helia, Zer	leun	1956
gove rise to couse (a), stating lying couse last.	the under-	uma · Car	line arent			400518
CATIC	HER SIGNIFICANT CONDITIONS					PERFORMED? YES NO
(IF EITHER, NOTIFY	MEDICAL EXAMINER)	SCRIBE HOW INJURY OCCU	RRED. (Enter noture of injury	in Port 1 or Port II of item 1	8.)	٠
20c. TIME OF INJUI Haur a. m. p. m.	While		PLACE OF INJURY (Home, for factory, street, affice bldg.,	orm, 20f. (City or town) etc.)	(Cour	nly) (State)
21. I certify the	hat I attended the decea		9 56, 19 , ta oth accurred at 12	1400 19 P. M. fram the caus	ses and an the	t saw the deceased
ACTUAL SIGNATURE	Hours &	Hall	M.D	ADDRESS (Street, city or		LEYOU.
PHYSICIAN'S NAME (Type)	HOWAYD E	HALL		MESVIL.	Le, M.	2,
220. BURIAL, CREMATIC		22c. NAME OF CEMETER	OR CREMATORY	22d. LOCATION (City, I	and or county)	Co. Mil.
23. FUNERAL DIRECTOR	S SIGNATURE	Hanlandle	240. RI DATE	OCT 2 1 '58	arthug &	Krasia.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## funeral director, id be filed with TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DI FOR: After this certificate has been signed by the attending physician and campletely filled in by the page 3 shauld detached for use as the burial-transit permit. Then please remove carban papers. Pages 1 and 2 the registrar prior to burial, cremation, ar remaval. and in any event within 72 hour other death.

VS A15 (4) 15M 9/55 M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11201 CERTIFICATE OF DEATH

Reg. Dist. No. 11193

1. PLACE OF DEATH o. COUNTY Cavroll MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institutions Residence o. STATE b. COUNTY	e before odmission)
b. CITY OR TOWN (If autide corporate limits, write c. LENGTH OF STAY IN 16 RUBAL and give nearest town)  Reveal Museuclesster 17 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and of	and the second
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Heavelvelle for 170 H/	Merchaeler P.O E/	e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print) LIZIE BLACK S	TERNER 4. DATE Month OF	Day Year 19-5-8
5. SEX 6. COLOR OR PACE 7. MARRIED NEVER MARRIED WIDOWED DIVORCED	1 - A A - A A - A	YEAR IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	- m	ZEN OF WHAT COUNTRY?
13. FATHER'S NAME Therey Black	14. MOTHER'S MAIDEN NAME TRAVER XECUTOR	P
	NFORMANT Heis Estee Sterver Macce	electo, mil
18. CAUSE OF DEATH [Enter only one cause per line for (o), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Coronary Arterios  420, / DUE TO	sclerosis	ONSET CHO DEATH
Conditions, if any, which gove rise to immediate couse (a), stating the under-lying couse lost.  (b) Hypertensive Cardinate (b) Hypertensive Cardinate (c)	io-Vascular Disease	20 <b>y</b> ears
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT Cardiac Liver Cirrhosis; Simple goiter;	Direct and indirect hernia:diabe	1(p) 19. WAS AUTOPSY B T BS PERFORMED? YES NO
OR CONTRIBUTING CAUSE OF DEATH 260 X	D. (Enter nature of injury in Part 1 ar Part 11 of item 18.)	
Coc. TIME OF INJURY Month, Day, Year   20d. INJURY OCCURRED   20e. PL/	ACE OF INJURY (Home, farm, 20f. (City or town) (Coctory, street, office bldg., etc.)	ounty) (State)
actual mc Parter lieux	n occurred at // 25 (2M), from the causes and an the ADDRESS (Street, city or town, stote)  M.D. Hampstead, Mde	ost saw the deceased e date stated abave DATE SIGNED 10.13.58
PHYSICIAN'S M. C. POrterfield, M.D.	Hampstead, Md.	
220. BURIAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY O. REMOVAL (Specify) Cet, 14 1958 Manchest	1 0 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	(State)
23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  ADDRESS  ADDRESS  ADDRESS  ADDRESS	Ly Co. REC'D BY REGISTRAR 246. REGISTRAR'S SIGN DATE OCT 1 5 '58 arily 2	

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VS A15 (4) 15M 10/57

1	MARYLAND 11202	202 CERTIFICATE OF DEATH		
	1. PLACE OF DEATH o. COUNTY CARROLL	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: o. STATEMARYLAND b. COUNTY	
M )	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN (If outside corporate limits, write RUR)	

11194

Reg. Dist. No.

	1. PLACE OF DEATH	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
	O. COUNTY CARROLL MARYLAND	O. STATEMARYLAND b. COUNTY CARROLL
	b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	WESTMINSTER RURAL 5 YEARS	X UNION BRIDGE
	d. NAME OF HOSPITAL (If not in hospital, give street address)  OR INSTITUTION	d. STREET ADDRESS  e. IS RESIDENCE ON A FARM?
	GLOVERS NURSING HOME	BENEDUM ST. YES NO DE
	3. NAME OF First Middle	Last 4. DATE Month Day Year
	(Type or print) SADIE ELITABETH STO	NESIFER DEATH OCT 20 19.58
	5. SEX   6. COLOR OR RACE   7. MARRIED   NEVER MARRIED	B. DATE OF BIRTH  9. AGE (In years   IF UNDER 1 YEAR   IF UNDER 24 HRS.   Hours   Min   Months   Days   Hours   Min   Mi
	WIDOWED DIVORCED	OCT 1-1867 G/yrs. Months Doys Hours Min.
	100. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDU during most of working life, even if retired)	ISTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?
/	HOUSEWIFE OWN HOME	MARYLAND USA
	13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
	JOHN BROWN.	MARY JANE BROWN
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. (Yes no, or unknown) 1 (If yes, give wor or dates of service)	INFORMANT Address MD
	NO NONE RO	LAND STONESIFER UNION BRIDGE
	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c).]	INTERVAL BETWEEN ONSET AND DEATH
	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	ceretral humanight 2 was
	33/X DUE TO	Dallandia J
	Conditions, if ony, which gove rise to immediate	Jecule 187112
	couse (o), stoting the under-	
	lying couse lost. (c)	
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BU	T NOT RELATED TO THE PERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19. WAS AUTOPSY PERFORMED?
	TO ACCIDENT WAS INDEPLYING IT TOO DESCRIBE HOW INTUING OCCURREN	ED. (Enter noture of injury in Port I or Port II of item 18.)
	200. ACCIDENT WAS UNDERLYING OF CONTRIBUTING OCCURRED OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFEY MEDICAL EXAMINER)	D. (Enter notice of injury in Fort I of Fort II of Hem 16.)
		LACE OF INJURY (Home, form, 20f. (City or town) (County) (State)
	Hour o. m. While Not while	sclory, street, office bldg., etc.)
		10 10 at a 70 . El.
	21. I certify that attended the deceased from 1700	1958, to 90, 1976, that I last saw the deceased
	alive an 1990, 1995, and that death	ADDRESS (Street, city or town, state)  ADDRESS (Street, city or town, state)
	ACTUAL TO DO ON LONG OLIN	15 Comment of the state of the
	SIGNATURE	M.D.
	PHYSICIAN'S FRESE VINE	No heatenmenters mid !
	220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY C	OR CREMATORY 22d. LOCATION (City, town, or county) (Stote)
	BURIAL 10/22/58 LUTHERIA	N IHNEYTOWN MD
	23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE
	DD Harryler & sons ymon D	eldge DATE OCT 23'58 arthur S. Kraus

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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1	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
FOR STATE	MEDICAL EXAMINER'S CERTIFICATE OF DEATH
EALTH DEPT.	Reg. Dist. No.  1. PLACE OF DEATH o. COUNTY ARROLL MARYLAND  2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Carroll
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)  ond give nearest lown)  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown)
Bo CO	d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address)  Westminster, Md. R. D. 2  Rural — Westminster  d. Street address  Westminster, Md. R. D. 2  e. IS RESIDENCE ON A FARM? YES TO NO
State death.	3. NAME OF GOLDIA First Belle Middle Wagner Lost 4. DATE Month Day Year
moy be with the ms after	5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTH 9. AGE (In years In UNDER 1YEAR IF UNDER 24 HPS.
age 5 r	100. USAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife—Housework  Her own home    100. KIND OF BUSINESS OR INDUSTRY   11. BIRTHPLACE (State or foreign country)   12. CITIZEN OF WHAT COUNTRY   13. BIRTHPLACE (State or foreign country)   14. CITIZEN OF WHAT COUNTRY   14. CITIZEN OF WHAT COUNTRY   15. CITIZEN OF WHAT COU
Pw3.	13. FATHER'S NAME  Elias G. Shipley  14. MOTHER'S MAIDEN NAME  Virginia Pickett
h form File p	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT AND W. Mugner, Westminster, Md. R. D. 2
iner's Office clong was a burial-transit permi	18. CAUSE OF DEATH [Enter anly one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a)  DUE TO  Conditions. If any, which gave rise to immediate cause (a), staling line underlying couse lost.  (c).
be used as	PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPSY PERFORMED?  YES NO PRIMARY OF CONTRIBUTING CONTRIBUTING CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH.
e Chief Moreld as to buria	CAUSE OF DEATH.  20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (Caunty) (Stote)  Haur o. m.
ld be for the rade to the ERAL Dictor: Page designated agent, principle	21. 1 certify that I took charge of the remains described above, held an Autopsy   , Inspection   Inquiry   , and in my opinion death esulted fram: Natural causes   , Accident   , Suicide   , Homicide   , Undetermined manner    ACTUAL SIGNATURE   M.D. CHIEF MEDICAL EXAMINER   ASSISTANT MEDICAL EXAMINER
TO FUN	220. BURIAL, CREMATION, REMOVAL (Specify) BURIAL  10/15/58  Zion Cemetery  ADDRESS  22c. NAME OF CEMETERY OR CREMATORY  REMOVAL (Specify)  Nr. Westminster, Carroll Co. 1  23. FUNERAL DIRECTOR'S SIGNATURE  ADDRESS  240. REC'D BY REGISTRAR'S SIGNATURE
A15ME 2/57	Pichard A. Fittle Littlestown, Pa. DATE 1 4 '58 arthur S. Trans

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		ters state
All mages (24 m region (2 might)) in the Committee of the		

	11100	CERTIFICA	ATE OF DEATH	Reg. Dis	st. No.
o. C	CE OF DEATH	MARYLAND	2. USUAL RESIDENCE (Where dec	eased lived. If institutions Residence b. COUNTY	ce before admission)
	CITY OR TOWN (If autside corporate limits, write c. URAL and give nearest town)	2 YUS	c. CITY OR TOWN (If outside a	corporate limits, write RURAL and g	give nearest town)
d. N	NAME OF HOSPITAL (If not in hospital, give street odds OR INSTITUTION	ress)	d. STREET ADDRESS 4 Bish	ap ah	IS RESIDENCE     ON A FARM?     YES    NO    NO
	ME OF EASED REBECCA -	- A - WH	GNER OF		1 - 19 498
5. SEX	VA WIDOWED D	DIVORCED [	8. DATE OF BIRTH May 10-1863	9. AGE (In years IF UNDER last birthday) yrs. Months	1 YEAR IF UNDER 24 HRS. Days Hours Min.
du	SUAL OCCUPATION (Give kind of work done 10b. KIN pripe most of working life, even if retired)	OF BUSINESS OR INDUS	n m	gn country) 12. CIT	We Sid
8	lijah Leffs		Elizabeth	arboug	h
(Yes, no.	IS DECEASED EVER IN U. S. ARMED FORCES? 16. SOC	no mi	y chas Mane	ha- Wester	winter My
18.	PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO	or (a). (b). ond (c).]	ralthy	mboris	INTERVAL BETWEEN ONSET AND DEATH
g	Conditions, if any, which aver rise to immediate ausse (a), stoling the under-	teris	recl.lar	2:0 140	bus
CERTIFICATION (L)	PART II. OTHER SIGNIFICANT CONDITIONS CON	TRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINAL DIS	SEASE CONDITION GIVEN IN PART	11(o) 19. WAS AUTOPSY PERFORMED? YES NO
	B. ACCIDENT WAS UNDERLYING ACCIDENT WAS UNDERLYING ACCONTRIBUTING CAUSE OF DEATH EITHER, NOTIFY MEDICAL EXAMINER)	E HOW INJURY OCCURRED	). (Enter noture of injury in Port I or	Part II of item 18.)	
MEDICAL 302	Hour o. m. 19 20d. INJURY Hour o. m. 19 20d. INJUR	Not while fac	CE OF INJURY (Home, form, 20f. lory, street, affice bldg., etc.)	(City or town) (C	County) (State)
	. I certify that lattended the deceased tive on Q 1953	7	accurred at 9 A.M.	1958, that I I fram the causes ond on the	ast saw the decease
	TUAL PROPOSOWY	Ekens		s (Street, city or town, stote)	DATE SIGNES
NA	YSICIAN'S F. REESE!	WILST	ENS		mass
13	MOVAL (Specify) Oct 7-1954	C. NAME OF CEMETERY OF	CREMATORY 22d LC	OCATION (City, town, or county)	md
23. 60%	de Supton He	ADDRESS empstead	MA 240. REC'D BY RE	GISTRAR 246. REGISTRAR'S SIG	

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital or attending physician.

• FUNERAL DIFFICE: After this certificate has been signed by the attending physician and completely filled in by page 3 shauld detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 the registrar prior to burial, crematian, ar removal, and in any event within 72 hours after death. may be retained b TO HOSPITAL OR

funeral director, Id be filed with

VS A15 (4) 15M 9/55

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## TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Poge 4 funeral director, may be retained by the hospital ar ottending physician. TO FUNERAL DESCRIPE: After this certificate has been signed by the attending physician and campletely filled in by page 3 shaulters detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 1 the registrar prior to burial, cremation, or removal, and in any event within 72 houg after death.

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MARYLAND	STATE DEPARTMENT OF HEALTH—BALTIMORE, 18	}
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	11206 CERTIFICATE OF			ATE OF D	DEATH Reg. D					11199					
1,	PLACE OF DEATH O. COUNTY Carroll				MARY	LAND	2. USUAL RESID		ere decease	d lived. If institution b. COUNTY Wash:	n Reside		re admiss	ion)	
		(If ou	tside corporate limi	ts, write	c. LENGTH OF STAY	IN 1b	c. CITY OR T	OWN (If or	utside corpo	rote limits, write R	URAL and	give nec	rest low	)	
	Sykesvi		ii iowiij		40 y. 2 m	. 2d	Hager	rstown	1	21	03.	2		1	
		PITAL (	If not in hospital, of State H		address)		d. STREET A	DDRESS						IDENCE FARM?	
	NAME OF	~~~	Fir		Middle	1	Los	1	4. DATE	Mon	lh	Do		Yeor	
	DECEASED (Type or print)		Henr	TV.	Newf	ton	Wisha	ard	OF DEATH			24	•	19 58	
5.	SEX	6.	COLOR OR RACE	*	RIED NEVER MARRI		B. DATE OF BIRTH			9 AGE (In years	IF UNDE		-		
	Male		White	WIDOW			unknow	n		last birthday)	Months	Doys	Hours	Min.	
100	. USUAL OCCUPA	TION (	Give kind of work life, even if retired	done 10b.	KIND OF BUSINESS C	OR INDU			or foreign c	ountry)	12. CI	TIZEN O	F WHAT	COUNTRY?	
	Lahorer		life, even if refired	'			Mars	vland				U.S.	Δ		
13.	FATHER'S NAME						14. MOTHER'S		AME			UAU	-		
	Joseph	LI4 el	and				Reh	acca F	Jolhne	nnan					
15.	WAS DECEASED &	EVER IN	U. S. ARMED FOR		SOCIAL SECURITY NO	). 17. 1	NFORMANT	BIGGS_I	TOTOLE	Add	ess				
{Ye	s, no. or unknown	Ill ye	s, give war or dates of s	ervice}	-		Springfie	eld Ho	ospita	1 Record	3				
	18. CAUSE OF E	DEATH	[Enter only one co	use per li	ne for (o), (b), and (c)							LINTE	RVAL BE	TWEEN	
		DEATH '	WAS CAUSED BY:									ONS	ET AND		
	420.0	IM.	MEDIATE CAUSE (d		rterioscle	#(o's.	MERITE (	115885	10			Y.	ars		
	Conditions, if		ediate												
	cause (a), statis	ng the	under- DUE TO	,											
7	lying couse for		1.	)											
ATIO					paranoid					culosis,		RT 1(0) 1	1(o) 19. WAS AUTOPSY PERFORMED?		
F	20a. ACCIDENT				CRIBE HOW INJURY C		advan	ced s	active				162	NO []	
ERTI	OR CONTRIBUTII	NG 🔲	CAUSE OF DEATH	200. 013	CKIBE HOW HAJOR! C	CCORRE	D. (Enter nature o	i injury in r	011 1 01 1 01	THO HEIR ID.					
ALC	20c. TIME OF INJ			1204 1	NJURY OCCURRED	20a BI	ACE OF INJURY (I	None form	204 (Cit.	y or town)				164-4-3	
MEDICAL CERTIFICATION	Hour a. r	n.	19	While at wor	Not while		clory, street, office			or town)		(County)		(State)	
	21. I certify	that	1 attended the	deceas	ed from 10/2	20/5	4	, ta	10/24/	58 , 19	.,that I	last so	w the	deceased	
	alive an	10/	24/58	. 19	, and that	death	accurred at								
	7	1	D	01		( )				treet, city or town,				ATE SIGNED	
	ACTUAL SIGNATURE	ny	anta	ing	Resulte	211	Mp. Spr	ingfie	ald_St	tate Hosp	ital	1	0/24	/58	
	PHYSICIAN'S NAME (Type)	Ju	lian Radz	ykew	yck, M.D.		Syk	esvil	le, Ma	aryland					
220	BURIAL, CREMA		226. DATE THEREC	)F	22c. NAME OF CEM	ETERY O	R CREMATORY		22d. LOCA	TION (City, town,	or county)		(Stot	e)	
	Burial Speci	iry)	Oct. 28	3,195	8 Green H	ill	Cemetery		We	ynesboro			Penn	A.	
23.	FUNERAL DIRECTO	OR'S SI			ADDRESS				BY REGIS			0 1 1		11-11-1	
	8 Ms	40,	1108	W	aynesboro.	Pen	na.	DATE U	127	30 C	rihun 2	. Ha	ue.		

Waynesboro, Penna.

Liggrand 16 , 6 CALLED A. REC'N. S. SELECT MANNEY STREET, SANSON, N. STREET, S. P. STREET, S. STREET, S. P. STREET, S. P. STREET, S. STREET, S the second secon Wilson Con State . many . or of premi